NATURE AND DYNAMICS OF HEALTH CULTURE: A CASE OF RURAL POPULATION OF TAMIL NADU

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by

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CERTIFICATE

It is certified that the work contained in the thesis entitled *"Nature and Dynamics of Health Culture A Case of Rural Population of Tamil Nadu"*, by *K Srinivasan* has been carried out under my supervision and that this work has not been submitted elsewhere for a degree

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Synopsis

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Alma Ata declaration in 1978 stressed the importance of health as, (i) a fundamental right of every individual to keep healthy, (ii) therefore, Primary Health Care is a fundamental right, (iii) it is everyone's duty to protect and to promote healthy environment for all Keeping above declaration in mind, it has become important for everyone to pay proper attention towards their health and the health care system of their society Health, as defined by experts means not only disease free status but to have fitness at all levels, physical, mental, social, economic, environmental etc

India is a signatory to the Alma-Ata Declaration which has pledged " Health for all by 2000 A D " This declaration has become a charter of health throughout the world and a hope for mankind, especially the deprived and the enriched masses in rural India Achievement of this goal, however, is not as simple as it may appear to be Viewed in the Indian context, it is beset with considerable operational problems at the planning and implementation stages

A critical issue concerning the success of health care is that individuals must be made knowledgeable on alternative means of care and therefore, community partici-

pation in all programmes of health care is a must By community participation one does not mean only the cooperation of the community with the medical and paramedical staff in implementing health-programmes, but also financial involvement of the community in meeting the health needs and in meeting the challenge of environmental sanitation, etc It is important to note that the Alma-Ata Declaration makes it clear that primary health care must be made "universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of the development in the spirit of self-reliance and self-determination" As things are, for rural population of India, it is difficult to achieve the above goal because of its financial and technical constraints

In a country with about 800 million people, no matter how great the efforts are on the part of the government, health policies cannot succeed unless the people realise that health should be their own concern and the government could at best provide supportive services at all levels In other words, the community must perceive health as one of its major concerns

However, many of us have not been able to generate some thoughts towards quality living, which is again essential for each one of us Consequently, lack of proper health care is commonly found in India which has been adversely affecting the quality-living

Can inequality be removed from health status? What is the dynamics behind it ? Is it dependent on individuals' attitude? Or it is dependent on the available resources like health administration, accessibility of facility? Is it culture- specific? A host of questions arise in our mind with reference to health-expenses or health care-system The present work is undertaken to answer some of the above questions through empirical examinations In addition to this, the present endeavour wishes to examine the applicability of 'sick role theory' which is the only theory to explain the behaviour of sick persons

It is well known that individuals alone cannot be held responsible for keeping themselves unhealthy, there are various factors involved in it However, according to "Sick Role Theory" the individuals only are held responsible for their sickness

Therefore, this theory is emphasising on individual role-performance in the event of sickness The assumption of the present study is that along with individuals there are various other factors involved in the event of sickness or health care Some of those factors are identified in the present study and they are termed as social correlates (factors) of health system of individuals

The study also wishes to examine the usefulness of Parsons' sick role theory for comprehending the role-behaviour of rural population The illness represents a form of deviance from normal duties But, unlike some other forms of deviance, being sick does not necessarily carry negative sanctions Indeed, within the value system there may be a positive encouragement, if not obligation, to withdraw from normal social roles By providing a motivation to deviance on the part of the sick, the social system improves the conditions for the restoration of health and at the same time, isolates the (transient) deviant in a specialised role system This has effect of reducing the visibility and the attraction of the deviant role to others

Our aim has been to provide a bridge by studying sick role as an outcome of Health Care system

Objectives

The overall thrust of the study is to understand the dynamics of health-culture of population for improving health-care administration and management in rural India However, following additional objectives were also kept in mind

1 to find out the interlinkages among the various units of health care,

2 to examine the impact of cultural orientation such as customs, rituals and dietary practices on health,

3 to understand the process of health care decisions made by individuals of the rural community of Tamil Nadu,

4 to familiarise with the administrative setup of rural health care units and their delivery system functioning in rural Tamil Nadu,

5 to comprehend the nature of relationship among the various levels of functionaries of health administration

6 to suggest some tentative theoretical formulation for the health dynamics of rural Tamil Nadu,

7 to suggest some steps for improvement in health care network with specific reference to rural population of Tamil Nadu

Hypotheses

Based on the above objectives, following hypotheses were developed for empirical verification

1 Stronger is the community bond, better is the health

2 Higher is the Socio Economic Status, better is the health

3 Better is the family care, less is the incidence of sickness

4 Greater is the health-discipline, less is the incidence of sickness

5 Preventive measures are more acceptable than the modern medicare

6 Cultural tradition influences the health-care decisions

7 Greater is the formalisation of health bureaucracy, better is the delivery system

Methodology

The rural population of Tamil Nadu is selected as universe of the present study because of its spectacular achievements in the health administration Since this study is of the health-culture of rural population, it was decided to choose two villages for making a comparative research design The total population of both the villages were interviewed for collection of desired information

Data Collection

For data collection, two sets of interview schedules were used One set was concerning with the health factors which was administered on the heads of the households who were the major respondents of the study The additional set of schedule was administrated on health officials Some questions were close ended and some were open ended In all 207 respondents as the heads of the house holds were interviewed The total period of data collection was spread into 7 months starting from November 1992 till July 1993 In the first phase the villagers(respondents) were contacted and were interviewed The second phase of filed work started in April 1993 and it finished in July 1993 In this phase, the hospital functionaries were interviewed for case-material

Structure of the Dissertation

The dissertation has seven chapters of which the first has a brief discussion on the theoretical framework The First Chapter also provides the main objectives of the study and operational definitions of certain key concepts as well as the major hypotheses

The second chapter deals with the research design, the selection of samples, techniques of data collection, scales used for measuring the socio-economic status etc This chapter also outlines the methodology of the present study Data were collected with the help of semi-structured interview schedule and participant observation along with secondary sources material

The third chapter is divided into two sections The first section deals with the profile of the village, describing the location, facilities, occupational structure, the caste composition etc In the second section, background data pertaining to the respondents such as their caste categories, age, size of land-holding, occupation educational-qualification and income In addition to these things, the respondents were categorised into various socio-economic status groups

Chapter four presents the factors influencing the health care decisions of the respondents in a social network- structure

The responses were analysed and two major findings emerged

- Health Care is a unit of complex system It is comprising of three major subsystems namely, self, community and health administration
- the health care choices are not made independently with reference to rural population of Tamil Nadu They are influenced by Socio Economic Status factors like age, affiliation, status etc

Chapter five focuses its attention on health as a product of disciplined practices and rituals In the cultural formation of rural population, religiosity found to be a very important factor in guiding individual's daily routine and some of these factors have roots in balanced health care

Chapter six is devoted to discussion on the Indian health bureaucracy and its delivery-system Weber's model of bureaucracy was examined on health administration and few modifications were suggested keeping the rural population in mind

Chapter seven is a concluding chapter It presents the summary of the findings of the present study

These findings provide us with very interesting insights to understand the nature and dynamics of health culture with specific reference to rural Tamil Nadu Some of the major findings are given below

- Individuals can not be held responsible for their sickness as assumed by Talcott Parsons
- Health is not a unitary unit but it is a system comprising of three sub-units They are self, community and health care administration
- Socio economic variables influence the health-care choices
- Dietary practices which are linked with the aspect of rituals and religiosity have role to play in health-culture

- Higher education is adversely affecting the health of rural youth The educated youths who normally migrate from the villages in search of jobs were exposed to health- hazards

- Centralised planning and administration of health bureaucracy affects its delivery system in the rural areas of Tamil Nadu

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I am indebted to my father who motivated me to take up higher studies and helped me with useful discussions and guidelines I am also very thankful to my sisters and mother for their love and affection provided throughout my carriei

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Contents

List of Tables

List of Figures

Chapter 1

Introduction

1.1 Introduction

Alma Ata declaration in 1978 stressed the importance of health as, (i) a fundamental right of every individual to keep healthy, (ii) therefore, Primary Health Care is a fundamental right, (iii) it is everyone's duty to protect and to promote healthy environment for all

Keeping above declaration in mind, it has become important for everyone to pay proper attention towards their health and the health care system of their society Health, as defined by experts means not only disease free status but to have fitness at all levels, physical, mental, social, economic, environmental etc

India is a signatory to the Alma-Ata Declaration which has pledged " Health for all by 2000 A D " This declaration has become a charter of health throughout the world and a hope for mankind, especially the deprived and the enriched masses in rural India Achievement of this goal, however, is not as simple as it may appear to be Viewed in the Indian context, it is beset with considerable operational problems at the planning and implementation stages Enormous efforts are required in the coming decade to attain the goal J P Naik, an eminent social scientist has once observed that "We have every right to be proud of our achievement in the field of health in post-Independent India But, it must also be realised that our failures

are even more glaring" Further, Prof Naik observed that the Indian health care system is still over-weighted in favour of curative programmes in spite of the clear indication that, in our present situation preventive aspects of health-care system is the only solution of our health-problems"(Naik,1975) A critical issue concerning the success of health care is that individuals must be made knowledgeable on alternative means of care and therefore, community participation in all programmes of health care is a must By community participation one does not mean only the cooperation of the community with the medical and para-medical staff in implementing health-programmes, but also financial involvement of the community in meeting the health needs and in meeting the challenge of environmental sanitation, etc It is important to note that the Alma-Ata Declaration makes it clear that primary health care must be made "universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of the development in the spirit of self-reliance and self-determination" As things are, there is a tendency on the part of the people in general, to demand free medical service, free supply of drugs, etc In short, it is taken for granted that the way to achieve better health is to create more and more free hospitals,and supply free drugs

This is the negation of the Alma-Ata Declaration It is pointless to argue that because in urban areas, hospitals are free for the poor, in the rural areas also health services should be free for the poor In a country with about 800 million people, no matter how great the efforts are on the part of the government, health policies cannot succeed unless the people realise that health should be of their own concern and the government could at best provide supportive services at all levels In other words, the community must perceive health as one of its major concerns

However, many of us have not been able to generate some thoughts towards quality living, which is again essential for each one of us Consequently lack of proper health care is commonly found in India which has been adversely affecting the quality-living

The inequality in health status with in the country is observable With regard to the per capita public expenditure on health a big range of variation is observed

among different states of India For example, in Bihar the average expenses incurred on health care is around Rs 15 60 (per person), in Madhya Pradesh it is Rs 27 20, in Andhra Pradesh it is Rs 25 40, while in Kerala it is Rs 36 80 The range is varying from Rs 15 to almost Rs 37 which is more than double The divergence in per capita expenditure on health also suggested certain amount of inequality

Can inequality be removed from health status? What are the dynamics behind it ? Is it dependent on individuals' attitude? Or it is dependent on the available resources like health administration, accessibility of facility? Is it culture- specific? A host of questions arise in our mind with reference to health-expenses or health care-system The present work is undertaken to answer some of the above questions through empirical examinations In addition to this, the present endeavour wishes to examine the applicability of sick role theory' which is the only theory to explain the behaviour of sick persons

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1.2 Rural Community and Health Care

The present study aims to study the health cultural dynamics of rural population of India Health is a composite unit of three major sub-systems namely, individual, community and health care administration Any individual can be seen as a product of some societal factors like his community affiliations, economic order, educational achievements, beliefs, practices, attitudes, customs and conventions, the consumption patterns etc

'Individuals' decisions of ones own health care is monitored by the group in which one is placed - a community Community (sub-system) is defined as a social unit living in a common locality, having a common goal and engaged in a common vocation

Therefore, community is seen to be a unit of similarities and solidarity Thus, the sub-system of community consists of interactive elements of its own such as individuals, physical environment, power, leadership, laws and social norms Individuals and community have overlapping regions with respect to health care-decisions

The third subsystem is of individual's health care administration and its delivery The 'health organisation' may form a system comprising of various sub-items The elements of health administration consists of health workers, health care network, the medicines, doctor,nurses, etc

The extent of interaction among the community, man and the health care network may determine the individuals' status of health

Indian society is a traditional one and therefore it gives lot of importance to customs and rituals However, religion, knowledge,beliefs, attitudes, food habits, physical comforts, family setup, education, and occupation,etc may also be of equal importance for rural population of India Therefore, all of them are included in individuals' health care system as its social correlates and the study plans to examine the extent of their impact on individuals' health Moreover, it is a task of the social scientists to investigate the life situation of individuals to discover the link between specific life situation and health- care Having identified the broad areas of the present study, it is worthwhile to have a quick glance at the available literature on health care and health dynamics of rural population of India This exercise will not only help us to locate the gaps in our knowledge about the problems of rural population with regard to their health-care but also to sharply focus our priorities in this study

1.3 Survey of the Existing Literature :

There are several studies on health issues in sociological literature They can be broadly classified into two categories

1 Studies conducted abroad

2 Studies conducted in India

1.3.1 Studies conducted abroad:

Studies conducted abroad can be categorised into following dimensions (1) doctor - patient relationship (2) sick-role performance (3) the bureaucratic structure of health administration (4) the health education (5) aging and health and (6) Impact of social factors on health

Over and above the biological symptoms of illness, pain, discomfort and physiological changes have been studied by Apple(1960), Banman(1961) and Twaddle(1969) They have stressed on functional incapacity of individuals as the crucial indicator of illness A study conducted by Mechanic (1964) has reported the importance of social factors like subjective assessment of role disruption and cultural and educational background of the sick individuals

In sociological literature, Parson's "Sick Role Theory" becomes a land mark theory to understand the cultural dimensions of sick person Parsons did mention that although the sickness was a physiological abnormality of the biological system, the experience of illness was a social event as in the course of illness the sick persons get involved in interaction with others (Parsons 1951) However, in his theory i e 'Sick Role Theory', Parsons has over emphasised on individuals role - performance and he ignored the importance of others The modification of sick role dimensions to fit mental and physical conditions other than the temporary and acute physical illnesses were discussed by Segall (1976), Arluke (1979) The extension studies along with these lines for psychiatric illness were conducted by Blackwell(1967), Denzin and Spitzer(1966), Petronic(1972), Sobel and Ingalls(1964) Likewise, some studies have been conducted to assess the impact of chronic diseases on individuals' role behaviour (Kassenbann and Banman 1965, Callahan 1966 and Thomas 1966)

A few studies have been conducted in recent years to suggest some theoretical framework to explain the various dimensions of illness Among them, Aim-

strong(1990) examined Foucault's theory of genealogical method for explaining the behaviour of patients suffering from chronic illness Armstrong supported the theory Pescosolido(1991) suggested a conceptual model of utilization and compliance on illness carrier

There are a number of studies suggesting the relationship between socio cultural factors and health Schoenbach et al(1986) studied social ties and mortality, Boyce et al(1986) studied social and cultural factors in Pregnancy, Johnson(1991) analysed the mental health, social relations and social selection, while Pillisuk et al (1993) studied the impact of social network and other psychological variables on health status of the aged persons

There are some studies on showing linkages between rituals beliefs and health conditions Vanx(1976) theoretically examined the importance of religion on health, Chan Ho(1985) studied dietary beliefs in health and illness Jarvis and North Cott(1987) studied the role of religion in morbidity and mortality, and Idler and Kasl(1992) studied Religion and other factors influencing health status

There are a few studies on health care administration and delivery system For example, Rhee (1977) studied physician patient interaction, Campbell et al(1990) on health delivery, and Bronstein and Morrisey(1991) on utilization of hospitals by pregnant women

The studies conducted abroad are mainly concerned with delirious effect of population growth on quality living of the urban dwellers But those studies totally ignored the rural population This lack is very natural because in western societies the facilities etc , are the same whether one is living in an urban centre or rural centre

1.3.2 Studies conducted in India:

Indian Studies mainly have focused on three aspects

1 Health education and its training curricula,

2 Villagers' health practices,

3 Health administration and doctor - patients' relationship

The pioneers in India are Pravathamma and Sharadamma (1965), Ahuluwalia (1967), M N Srinivas, A M Shah and M S A Rao (1974)

Their main interests were in the area of social correlates of medical education and social structure of medical organisation in India

A few studies have shown interest in the health concept of villagers (Carstairs (1955), Marriott (1955), Opler (1963), Hassan (1967), Dairmont (1980)) These studies noted different kinds of medical practices were followed in the villages of India Lewis (1958) and Gould(1965) have found that villagers are pragmatic and flexible in their approach and are willing to try anything if it works Minocha (1974) study pointed out that some diseases might be cured with the help of indigenous medicine However, because of the lack of proper knowledge, the doctors were forced to use modern allopathic medicines

Madan's study on households of an urban fringe found that choice to use modern medicine have association with the various socio economic characteristics of its users This study is in the context of medical system in India Dube (1970), Sethi et al (1974), Sethi and Sinha (1977), have studied the prevalence rate of mental illness in rural and urban areas Mathews(1979) studied the theory of behaviour change and insights obtained from social psychology, sociology and anthropology are used in health education Banerji (1981) studied the role of caste and religion in terms of specific behaviour of individual groups in the power structure and related this to their health culture Kamble(1984) made an attempt to link social and economic factors with morbidity in rural areas Dumont (1986) studied the role of magic and other beliefs among a south Indian caste in health

The review of above studies revealed the social aspects of diseases Almost all those studies were conducted on urban population Thus, the studies have neglected the rural community India is a country with the majority of population living in rural areas Therefore, one has to pay attention on issues and problems related with the rural community The present study aims to fulfil the gap by studying the social and cultural consequences of illness of rural community

No study in India has so far examined applicability of Parsons' sick role theory with reference to the cultural practices of rural population This study wishes to do this

1.4 Theoretical Framework

The present study aims at examining the nature and dynamics of health culture of rural Indian population In sociological literature, only one theory is linked with the cultural aspects of sick persons that is Parsons' Sick Role Theory Parsons' theory is understood in the action frame of reference of functionalist perspective It is a mark of Talcott Parsons's penetrating originality that he brought forward an apparently natural event, the process of becoming ill and seeking medical treatment, as an appropriate object of sociological analysis The concept of the sick role first appeared as part of a case study of modern medical practice to illustrate the inter-relationships among the elements of the SOCIAL SYSTEM (1950) The maintenance of health is an overriding practical necessity for all societies In a complex division of labour sickness and healing are well-developed social activities involving publicly organised insurance schemes and large-scale total institutions for housing the sick This is so because illness represents a form of DEVIANCE from normal duties But, unlike some other forms of deviance, being sick does not necessarily carry negative sanctions Indeed, within the value system there may be a positive encouragement, if not obligation, to withdraw from normal social roles By providing a motivation to deviance on the part of the sick, the social system improves the conditions for the restoration of health and at the same time, isolates the (transient) deviant in a specialised role system

This has the effect of reducing the visibility and the attraction of the deviant role to others the social regulation of sickness is entrusted to the physician who is invested with the authority to admit and discharge individuals in their passage through the sick role. In carrying out this role the physician's behaviour is subject to three basic norms affective neutrality (social and emotional distance), universalism (equality of

treatment), and functional specificity(narrow technical specialisation)

The sick role has four major elements

(1) Depending on the severity of the sickness, the individual is exempted from normal obligations and (2) is not held personally responsible for his conditions He cannot help it, recovery is not a matter of violation, and it involves the intervention of others But (3) at the same time the sick person should view his condition as undesirable and should not take advantage of any secondary gain from being the centre of concerned attention to prolong his indisposition(4) As part of this, there is a related obligation to seek technical qualified help and to co- operate in prescribed therapy

That the concept of the sick role has attracted a large volume of critical attention is testimony of its importance, especially in the development of medical sociology But in providing a paradigm for the analysis of the doctor/patient relationship, it has tended to be separated from the systematic model of social structure of which it was intended as no more than an interdependent part Critics have been quick to point out that the empirical evidence of sickness and its treatment deviates in substantial ways from Parsons's IDEAL TYPE which seems to be founded on the narrow organic disease model of positivist medical science As such it embodies an image of sickness as acute , morally neutral and objectively observable, of the sufferer as the incompetent and passive professional client, and of the physician as an altruistic practitioner who puts relief of suffering above all

All of these assumptions carry problems Disorders of health are frequently chronic, if not permanent disabilities, which involve personal initiative and adjustment rather than medical cure In such cases the incumbency of the sick role is not a temporary interlude and it may therefore involve long term deviance Equally, many conditions, for example venereal and smoking-related disease, are not free of moral valuation Some others may never even be recognised as legitimate disease either by their victims or by those with the authority to diagnose So the sick role is relevant to only a limited range of sickness and even then there may be obstacles to deter the would-be incumbents, such as the high cost of available medical care

The shortcomings of the sick role as a paradigmatic model have acted as inspiration

in the development of research on the doctor-patient relationship Most studies have focused on the degree of mutuality in interaction The best-known, that of SZASZ and Hollander (Archives of Internal Medicine,1956), distinguishes three ideal types according to context and type of medical problem (1) activity/passivity, appropriate to treatment of medical emergencies when the patient is not even conscious, (2) guidance/co-operation, appropriate to on- going medical treatment where the sentient patient respects and follows doctor's orders, (3) mutual participation appropriate to chronic conditions where treatment depends on a high degree of involvement on the part of the patient Underlying each of these is an assumption of an harmonious reciprocity of interests which other research has called into question Freidson points to a fundamental tension arising from the discrepant expectations of doctor and patient

The detached approach of the doctor to what is no more than a mere case must clash with a committed involvement of the client, for whom the consultation might be a matter of life and death That such encounters would provoke anxiety, even conflict, has been frequently verified in research and it seems that disappointment with role performance is not confined to patients

Doctors also report their own frustrated expectations of patients who are insufficiently discriminating in the problems they bring to the surgery, insufficiently deferential in consultation, and frequently non-complaint in the process of treatment Other research presents professional practice in a more sinister light, revealing the techniques of information control employed by physicians to induce ignorance and uncertainty on the part of clients and thereby to protect the process of treatment from critical scrutiny The empirical record thus casts some doubt on the fit between the ideal attributes of the sick role and the real experience of illness and its treatment In reviewing the sociological utility of the concept a distinction should be drawn between its usefulness for the analysis of the doctor - patient relationship on the one hand and for the force of medicine as an agency of social control on the other Of late 1950 'Sick role theory' has generated extensive research interest Most of them were on modifying the sick role dimensions to fit mental and physical conditions other

than temporary acute physical illness as discussed by Parsons (Segall, 1976)

In recent studies some controversies have been raised A few studies have argued that the sick role of expectations described by Parsons fail to capture the empirical viability of expectations that people bring to the illness situation (Twaddle, 1969) and may in fact fail to capture the cognitive content with which individuals think about illness (Berkanovic, 1972) While some others have argued that value consensus of these expectations is not as high as Parsons suggested even within the context of the single role he described (Segall, 1976) Moreover, some studies have reported various flaws in the 'sick - role theory' to explain the behaviour of sick persons because it has not paid attention on other aspects of society which may influence sick person's behaviour

In all the studies conducted on 'Sick Role Theory' there are some important points worth noting

- The empirical tests of this thesis have so far been attempted only on samples of highly urbanised and developed nations who have experienced 'sickness' as an undesirable event and the medical help is uniformly accessible to every one
- Secondly, most of the empirical studies have accepted the importance of sick role expectation and role performance
- Thirdly, all of these studies have centred their attention on various kinds of sickness for Sick-role performance per se without attempting to link it with various differences in socio-economic conditions, differences in socio-economic status, and with differences in community bonds or health - management etc
- Lastly, all of these studies have ignored to point out health in a systemic structure where it is dependent on chain - interactions (network situation) among various sub-systems of the "Health - System" such as, self (individual), community and health - administrative units

1.5 Objectives

This study attempts to fill the vacuum essentially by examining, firstly, the utility of the concept of 'Sick - Role Theory' for the rural population of Tamil Nadu The setting is of a developing society and we wish to examine the impact of cultural tradition on sick individuals Secondly, to introduce the concept of "health-system" to assess the importance of "network-structure" on health-care choices made by the rural people

Thus, the overall thrust of the study is to understand the dynamics of health - culture of rural population for improving health - care administration and management in rural India However, following additional objectives were also keep in mind

1 to find out the inter-linkages among the various units of health care,

2 to examine the impact of cultural orientation such as customs, rituals and dietary practices on health,

3 to understand the process of health care decisions made by individuals of the rural community of Tamil Nadu,

4 to familiarise with the administrative setup of rural health care units and their delivery system functioning in rural Tamil Nadu,

5 to comprehend the nature of relationship among the various levels of functionaries of health administration as well as the rural population,

6 to suggest some tentative theoretical formulation for the health dynamics of rural India,

7 to suggest some steps for improvement in health care network with specific reference to rural population

Based on the above objectives, following hypotheses were developed for empirical verification

1.6 Hypotheses

1 Stronger is the community bond, better is the health

2 Higher is the Socio Economic Status, better is the health care choices

3 Better is the family care, less is the incidence of sickness

4 Greater is the health discipline, less is the incidence of sickness

5 Preventive measures are more acceptable than the modern medication

6 Cultural tradition influences the health - care decisions

7 Greater is the formalisation of health bureaucracy better is the delivery system

We hypothesised that the average villager wanted to keep themselves fit with the help of alternative means than the medicines Therefore, we expected lowei level participation of rural communities in modern system of medicaie

Having formulated the objectives and hypotheses in the clearest possible terms, it is necessary to explicate and define the important concepts used in this study

1.7 Concepts and Definitions

Health The etymological meaning (which has originated from the word 'heal') suggests soundness of body or healthy condition of body However, according to World Health Organisation Directory health means fitness at all levels, physical, psychological, social, economical, environmental etc In common use the word health denotes absence of diseases In the present context we prefer to use World Health Organisation definition of health

Health - Culture The major emphasis of the term is on the 'cultural' aspects of health culture means all shared norms, institutions, beliefs, practices, ideas of a society Culture includes the material aspects (tools, instruments, products, plans etc) and the non-material aspects (religious beliefs, ideology, social norms, sanctions,

symbolism etc) Therefore, health - culture connotes all ideas, practices symbolic artifacts of certain human - groups those are used for promotion of the aspects of health

Bureaucracy Initially referring to a cloth covering the desks of French government officials in the eighteenth century, the term "bureau" came to be linked with a suffix signifying rule of government (as in "aristocracy" or "democracy") probably driving the struggles against absolutism preceding the French Revolution

According to Weber, a bureaucracy establishes a relation between legally instated authorities and their subordinate officials which is characterised by defined rights and duties, prescribed in written regulations, authority relations between positions, which are ordered systematically, appointment and promotion based on contractual agreements and regulated accordingly, technical training or experience as a formal condition of employment, fixed monetary salaries, a strict separation of office and incumbent in the sense that the official does not own the "means of administration " and cannot appropriate the position, and administrative work as a full-time occupation

Role

When people occupy social positions their behaviour is determined mainly by what is expected of that position rather than by their own individual attributes Thus, role are bundles of socially defined attributes, and expectations associated with social position The role theory was derived from R Linton(1936) and was subsequently incorporated into functionalism Thus, the functionalism suggests that actual roles often demonstrated a considerable interdependence with the role set

The Sick Role

It is a mark of Talcott Parsons's penetrating originality that he brought forward an apparently natural event, the process of becoming ill and seeking medical treatment is a role obligation for sick individuals The concept of the sick role first appeared as part of a case study of modern medical practice to illustrate the interrelationships of the principal elements of the Social System(1950) The maintenance of health is an overriding practical necessity for all societies In a complex division of labour, sickness and healing are well-developed social activities involving publicly organised

health care units

Community A set of social relationships which takes place wholly are mostly, within a bounded local territory The term is used in the study of non-tribal societies, particularly within Western national states as an organising principle, community takes the place of KINSHIP in the study of tribal groups Community studies tend to concentrate on rural areas or on localised urban groups In either case there is a strong spatial component in the definition of community Community is often opposed to large structures, such as the STATE In classical formulations which follows TONNIES and WEBER on CLASS, communities are IDEAL TYPES in a continuum which stretches between two poles These may be implicit and descriptive-such as the contrast between rural and urban society, or tradition and modernity-or they may emphasise particular types of social relationship Thus 'close' ties of kinship and status in a community are opposed to 'loose' contractual relationships between individuals who experience no other type of relationship within settings characterised by a high DIVISION OF LABOUR

There are three main sub-approaches to community (1) As locality - a geographical expression denoting a human settlement within a particular local territory This is not a sociological definition In that there is no consideration of the inhabitants or their interactions (2) As a social system - a set of social relationships that take place wholly or partly within a locality This is more sociological usage, since it refers to a network of interrelationships between people living in the same locality, however, this definition refers to the structure of these relationships, not their content (3) As a type of relationship-that is, as a sense of identity among individuals, having no geographical (local) referent at all since this sense of identity may exist among geographically dispersed individuals This notion of community, with its overtones of common identity, is best termed 'communion' since this more clearly conveys the sense of meaningful identity and shared experience

Social Network "Social network" conveys the following set of ideas Individuals (or larger social units) are perceived as being "significantly" in direct contact with many others but not with all possible others Indirect contacts, through one or more

intermediaries, may also be significant An individual may sometimes, if he or she makes an effort, succeed in making direct contact with someone to whom he or she has hitherto been linked only indirectly, indeed, this is one of the main ways in which individuals make new direct contacts Intermediaries may facilitate or obstruct this process of converting contacts from indirect to direct, or may endeavour to interpose themselves as a barrier or filter between individual and a direct contact

Contacts between individuals may take the form of channels of communication, or of the flow of resources, or may manifest themselves merely the expression of attitudes and sentiments Whatever form the contact takes, it may affect the behaviour of the individual Since every individual has her or his own set of contacts, the pattern of contacts as a whole affects the behaviour of the collectivity and is, simultaneously, an outcome of that behaviour

Most of the occurrences of the term "social network" in social science that are more than twenty years old, as well as most of the popular uses of the term, imply no more than the very general and quantified ideas just listed The ideas are uncontroversial and can scarcely be regarded as testable propositions They constitute orienting notions and nothing more (Homans, 1967) On the other hand, social scientists in recent years have used "network" as a precise term and have developed definitions to generate testable, often quantified propositions

Different practitioners have tried to propositionalize and quantify network notions in different ways In the great majority of instances, social science references to the social network are still confined to the very general ideas that have listed, and the only measurement involved consists in counting the number of contacts impinging on each of a collection of individuals Indeed, the use of "personal network" as a technical term for an individual's direct contacts constitutes a striking case of what we might call "operationalization by impoverishment" By confining attention to direct contacts, this definition eliminates the value of the term "network" as an orienting idea

Total Network - Total networks are such as are not defined by selection of a particular person or group as the focal point or "ego" Barnes conceives of a total network as "an interconnected chain or system of immaterial things" It has no units

or boundaries it has no co-ordinating organization It is made up of the ties of friendship and acquaintance Some of the ties are between kins men Each person, as it were, is in touch with a member of other people, some of whom are directly in touch with each other and some of whom are not Both of them also included both kinds of relationship direct and finite as well as those which are mediated through the families individuals with which a family individual has direct relationship

Religiosity

Religiosity is performance of various kinds of ritualistic actions The term can be operationalised based on the specific situation In this study the term is used with reference to a designed set of rigid norms and practices(See Chapter II)

Folk-medicine

The medicinal practices which are used to maintain health of the rural population These medicines are not documented properly and they are available in the form of traditional practices

Chapter 2

Research Design

In the introductory chapter, we have been able to formulate the problem of the present study along with the major objectives and hypotheses In this chapter, the frame-work of the empirical study (research-design) is explained The various steps involved in the study have been delineated in the following paragraphs

2.1 Universe

The rural population of Tamil Nadu is selected as universe of the present study because of its spectacular achievements in the health administration

Tamil Nadu is one of the twenty five states of India and it is situated in southern part of India Tamil Nadu is surrounded by sea on the two sides, western ghats on the western side and plain lands in the northern side The state Andhra Pradesh is in the northern side and the state of Kerala is on the western side of Tamil Nadu In the eastern direction there is Bay of Bengal and on the south there is Indian ocean (see the geographical map of Tamil Nadu in Annexure A)

Tamil Nadu is spread over an area of 1,30,058 sq km The total population of Tamil Nadu is 5,56,38,318, in which literate population is 3,03,83,416 The per capita income of the state is Rs 2096 (1991 census report)

Tamil Nadu's literacy was less than 50 percent in the eighties and it is above 55 percent in nineties It is driving towards cent percent literacy through the National

Literacy Mission Project Already a few districts of the state have been able to achieve cent percent literacy in the state

Health for all by 2000 has been claimed to be achieved through Tamil Nadu's highly concerted action For example, birth rate is brought down to 20 6 per 1000 which is a target set to achieve by the year 2000 AD for the entire country by the Ministry of Health and Family Welfare Further, Tamil Nadu is in the threshold of attaining zero population growth rate The infant mortality rate has been lowered down too, i e 37 per 1000 (in Tamil Nadu) against the national average of 60 per thousand

2.2 Locale

Since this study is of rural health it was decided to choose two villages for making a comparative research-design Selection of the villages were made keeping two points in view ,

firstly, one village to be chosen from those ones which were very close to the district headquarters Thus, the rural population of this village might have easy access to modern facilities, with specific reference to proper health care facilities, and

secondly, another village to be chosen from the villages which were far off from the district head quarters or a city It is assumed that the rural population of this 'remote' village would not have access to modern facilities And they might be able to keep intact their rural character

Keeping the above points in view, Naduppatti and Sangalpatti of Dindigul Anna District have been selected as locale of the empirical study

Dindigul Anna district is of special interest because it is a newly formed district Previously this district was a part of Madurai district The health organisation of the newly formed district is very well organised This district has a history and it also contains some tribal population along with non-tribals The total area of the district is 6058 sq km while, the total population of the district is 17,68,679 (1991

census report) This fact suggests that the population density of this district is not very high

Naduppatti village (now onwards called as Village A) is a 'remote' village (i e far off from the headquarters) In this village modern facilities including health facilities are not very easily available since it is far off from the district head quarters or any other town It is a village in Kodaikanal Taluk in the lower Palani hills of Western Ghats.

While Sangalpatti (now onwards called as village B) is a village very close to the district headquarters therefore, this is named as 'vicinity village' In this village all facilities including health facilities are very easily available

Village A consisted of both Tribal and Non Tribal population while village B only consisted of Non Tribal population Village A had 51 households while Village B had 156 households. The heads of the households of both the villages where chosen as the respondents of the study through census method

Table 2 1 The Respondents Details

Village A House holds	Village B House holds
House holds -51*	House holds - 156

* 11 House holds were of tribal communities

The study plans to develop a comparative frame work to identify the differences between the respondents of Village A and Village B with regard to their socio-demographic characteristics and health behaviour The detailed discussion on those differences are given in Chapter III

2.3 Data Collection

The respondents belonged to two major categories The major data were collected from the heads of the households as respondents of the study and the information collected from health officials of Primary Health Centers and missionary hospital of

the villages were used for developing case-materials to understand the various aspects of health bureaucracy and its administration

'Health' has two distinct aspects, one is individuals' concern for their own health and another is the health administration Thus data were collected with the help of two set of interview schedule One set is concerning with the health factors which was administered on the heads of the house holds whowere the respondents of the study The additional set of schedule was administered on the health officials, such as, the Medical Officers, the Health Supervisors, Health Assistants, Sector Health Nurses, and Village Health Nurses to collect the case-study materials In addition to above technique, participant observation, case-studies and secondary sources were used for the collection of desired information

The set of interview schedule which was administered on heads of the households, was divided into three major parts These parts covered the questions on the following aspects, daily practices or way of living, food and nutritional, intake, personal hygiene and sanitation, occupational activities, attitude and awareness towards health-programmes, and socio demographic details and community orientation for health activities

The second set of the interview schedule had questions concerning the health administration and management In this, focussed questions were asked to deal with the nature, domain and problems of health delivery units as well Therefore this set was only administered on the health personnel of P H C s and hospitals

The first phase started in November 1992 and went on till the period of January 1993 In April 1993, second phase has started and it continued till July 1993 In the first phase, the researcher pretested the tool, finalised the tool after some minor modification and then tried to administer the tool on the respondents to collect information The health personnel could not be interviewed in the first phase After a month the second phase of the study started In this phase, the health personnel were interviewed along with the other respondents Total period of data collection was almost of 8 months

2.4 Field Experiences

During the field work there were many problems faced by the researcher Village A which was the remote village did not have proper transport facility Therefore, the researcher had to trek to the village He walked at least 10 k m s a day on an average to reach to the village In addition to that Village A was isolated and therefore, it was without any facilities and it did not have any form of contact with the outside world For rapport building with the tribal people, the researcher has to put sustained efforts for a few weeks After a few weeks, the researcher could gain the confidence of the villagers and they started becoming free

Likewise, in Village B initially the villagers were suspecting the researcher's motive and therefore they were meeting with reservations Continued stay for a couple of weeks made the villagers more comfortable and they started opening up with the researcher later on Thus, after a few weeks of stay, the data collection became very smooth and trouble free By the time the study was coming to an end, the researcher had become a part and parcel of the village community

The in-depth interviews and observation were helpful in providing insights to understand the respondents' concerns and the major issues of rural health-administration The analyses of compiled information are given in the forthcoming chapters

2.5 Measurements

Assuming that considerable differences among the respondents of remote and vicinity villages would be noticed and since we were interested in measuring the levels of extent of health facility and socio economic status, it was essential to develop a proper scale that would enable us to test some of the hypotheses It had been hypothesised that the level of health varies from one socio-economic strata to another among the villagers To identify these strata distinctly it was essential to determine the socio economic status (hereafter SES) of each respondent For that we used the SES scale developed by Kuppuswamy but with some modifications

In the Indian society, the importance of caste as a determinant of one's socio economic status can hardly be overemphasised In addition to that age is also taken for the measurement of SES The SES scale was developed taking five variables into account, viz caste, age, income, education and occupation In addition to caste, age is an important variable, if one is trying to study the health aspects of a population Therefore, age is included in SES as one of the objective measures Barring caste, other variables are almost universally recognised as indicators or as objective criteria of socio economic status For example, the Occupation Prestige Scale used by Lipset and Hatt takes occupation as the main indicator of prestige Some other empirical studies have tried 'Family Rating Scale' in which they have used income, education and occupation, religious and ethnic characteristics Caste is a factor that is unique to Indian Society Hence, rural population of India would not be complete unless it takes into account their caste status wherever it is necessary Therefore, in the present investigation we have included caste as one of the variables to objectively measure SES of the respondents For the objective criteria of SES ranking we used 'income', 'education', and 'occupation', as the three indices following mainly Kuppuswamy's method as stated above. For the index of income a 5-point scale was developed as shown in Appendix The income earned by individual respondent as then divided into three categories, 'high', 'medium', and 'low' The cutting points here were decided upon by calculating the mean score Thus, the cutting points were Rs 600/- or less per month for the low income and Rs 2000/- or more for the high income In this way income categories 1 and 2 had come into 'low' income group, 3 as the 'medium group' and 4 and 5 into 'high income group' (see Appendix B) Similarly, educational achievements of the respondents were measured by years of formal education in an educational institution and the scale was divided into three categories 'high', 'medium', and 'low' The cutting points here too were decided upon by calculating the mean score Thus, the cutting points were up to class fifth or low educational achievement In this way three educational categories were made 1 and 2 were in 'low' level educational category, 3 and 4 into medium level and 5 and 6 were placed into 'high level' educational category which are given in Appendix (see

Appendix B)

For rating occupational status we had to seek the help of some judges We found that Kuppuswamy's ratings of occupations were rather subjective and arbitrary To avoid possible bias, we asked some five judges to impartially give their ratings of different occupational categories which the respondents belonged to The cutting points of the occupational categories are shown in the Appendix (see Appendix B) Similarly, we sought the help of other set of five judges for ranking [illegible] reported by the respondents as well The caste rating procedure is detailed out in the Appendix B Care was taken in selecting only those judges known to be well- versed in the occupational ratings and who know the intricacies of hierarchical structures of castes of the study area

Using thus, the judges on occupation and caste and following Kupppuswamy's method for ranking income and education, we assigned numerical scores to the responses of each individual respondent on the five separate scales and then added these to get the total score in each case Taking these total score into account we classified the respondents into three - 'high', 'medium', and 'low' - SES categories which were decided upon after calculating the mean score and the quartiles of total scores The sample cases who came into the first quartile were placed in low SES category, those in the second quartile were placed in medium SES category In the fourth quartile there were very few cases, hence we combined the third and fourth quartiles to form a single category of 'high' SES The SES ranking was done on a 15 point scale

2.6 Measurements of Religiosity and Health Statuses.

On the basis of the observations during the field work, the following items as indicators to measure the levels of religiosity and levels of health were developed Religiosity can be measured through identifying the various kinds of daily rites

To determine the degree or extent of the respondent's religiosity the following four

indicators were used

1 Visit to place of worship

2 Celebrating religious ceremonies

3 Attitude and ritual performance

4 Restriction on dietary practices

Respondents who visited to the places of worship daily were assigned 3 points, the respondents who visited to places of worship once in a week were assigned 2 points, and the respondents who visited to places of worship once in a month or occasionally were assigned 1 point For the questions on religious ceremonies and rituals, 1 point to each positive response and zero value for negative responses were given For the respondents who kept fast and maintained restriction on diet at least once in a week were assigned 3 points, the respondents who kept fast once in a month and some restrictions on diet were assigned 2 points, and who kept fast once in a year or occasionally and who maintained occasional restriction on diet on some specific days were assigned 1 point The total score ranged from 2 to 8 Those who secured 2 points were placed in 'Less religious' category, those who scored 3 to 5 points were place in 'Moderately religious' and those who secured 6 to 8 points were placed in 'highly religious' category Thus, the scale was divided into three major categories less religious, moderately religious, and highly religious

Likewise, to assess the extent of 'good health' the following five indicators were used

- Incidence of sickness,
- use of physical health measures,
- paying attention towards personal hygiene,and getting help from family members
- consumption pattern, and
- sanitation

For all questions 1 point to each positive response and zero point to each negative response were assigned The aspect of sickness was inclusive of frequency, type and duration

The total score ranged from 0 to 5 Those who secured upto 1 were placed in 'less healthy' category, those who scored between 2 and 3 points were placed in 'moderately healthy' category, and those who secured 4 and 5 points were placed in 'highly healthy' category Thus, the scale of health-status was divided into three major categories less healthy, moderately healthy and highly healthy

Chapter 3

Village Profile

In previous chapter (Research Methodology), the procedure adopted for the selection of study - villages was mentioned Keeping the selection - criteria in mind two villages were selected, one which was very close (vicinity) to the headquarters i e Dindigul and another which was far off (remote) from the district headquarters For easy reference we plan to use the 'vicinity village' for near one, whereas, 'remote village' for the far off one The Remote village's name is Naduppatti, from now onwards, it will be addressed as Village A Village A(Naduppatti) is situated at Periyur Village Panchayat of Kodaikanal Taluk Another village is Sangalpatti, a vicinity village, From now onwards it will be called as Village B Village B,"the vicinity village" is situated at Kottur village Panchayat of Nilakkottai Taluk The following paragraphs are presenting the profile - attributes of both the villages along with the socio demographic profile of the respondents of the study

3.1 Village Profile

3.1.1 Village A

Location

The Village 'A' is a hilly village in Western Ghats Those hills are known as Lower Palani Hills The Western Ghats have dense forests It is 1500 meters above Mean Sea level In east of the village, there is a village called Kilakku Chettipatti It is

three kilometer away from the village In the west, at a distance of six kilometers the village Paichalur is located The village A is 30 Kilometers away from Kodaikanal Town The village 'A' is 1 km away from the village Periyur which is the most well known settlement of the vicinity The village is dependent on coffee-plantation and paddy cultivation for its economic resources

Facility

In village A the facilities are poor Because of its location in hills, it has not been given attention to improve physical facilities like transportation, communication etc Sometimes in emergency people have to travel fifty kilometers to reach to a hospital for their health care Transportation is an important facility However, one has to walk minimum of three kilometers in case of getting a vehicle like bus or truck which is only available at K C Patti village which happens to be 3 kilometers away from the village 'A' This suggests how difficult is to reach to this place and how much isolated this village 'A' is! The connecting roads are unmetalled, and therefore sometimes one has to use foot paths

Electricity is available in the village only for domestic and agricultural purposes There is no arrangement for street - lighting in the village For drinking water, villagers have tube wells and a stream in the eastern side of the village The Government Health Sub Centre is in Periyur village, which is one kilometer away from the village Whenever some health-need arises, one has trek to Periyur health sub centre The health sub - centre of Periyur village does not have any doctor but has a trained mid wife who is supposed to take care of patients Thus, the village health sub - centre actually, in real terms does not have any proper provision of health - care During emergency conditions, one has to go to the Primary Health Centre in Poolathur which is thirty kilometers away from village A However, the village 'A' has some scanty type of health centre run by a non governmental agency known as Christian Fellowship Hospital, Amblikay In this mission hospital a trained nurse is always available for consultation and facility emergency check-up is available round the clock This hospital is located at one of the tribal settlements and actually this missionary health centre is only meant for the tribal families of the village However,

in emergency, the health - staff of this hospital do take care of others also In addition to this, everyday a Homeopathy doctor(a private practitioner) from K C Patti visits the village Sometimes people go to the Homeopaths as well as the quacks for their treatments

The village 'A' neither has drainage facility nor market facility The Co-operative marketing society is in Santhanapalapatti, two kilometers away from the village There are two petty shops in the village These two shops hardly keep any medicine

The village has a school up to eighth standard with free hostel facility In this locality only this village has this kind of school Therefore, the school is very popular Since this school has hostel facility, many students come from the nearby villages A nutritional meal centre is also attached with it There is an 'Anganwadi'(ICDS centre) in the village In that centre nutritious diets are distributed to children (of below three years age) and to the pregnant women during the period of pregenancy The Anganwadi also distributes iron tablets to the young mothers

For veterinary purposes, villagers have to go to K C Patti There is no post office in the village 'A' However, an extension counter of Post Office is available at the village 'A' The above description suggests that the village 'A' lacks in most of the basic facilities like transport, metal road, hospital, street light post office, etc

Occupational Structure

In village A, half of the residents are farmers engaged in farming on their own land The other half is divided among the Agricultural Labourers and Services (see Table 3 1)

Table 3 1 indicates that more than 91 percent of respondents were engaged in agricultural activities, either as farm - owners or agricultural labourers, while, around eight per cent were engaged in services It is generally thought that in village no one would be engaged in occupation (services), but, this is not true in the case of village A However the note worthy point is that little more than 41 percent residents of the village 'A' are landless and they work on others land as agricultural labourers

Caste Composition:

Table 3 1 The occupational details of Village A

Occupational Categories	Number	Percentage
Farmers	26	50 98
Agricultural Labourers	21	41 17
Services	4	7 84

Table 3 2 describes the caste composition of village 'A ' Table 3 3 indicates that Mannadiyars are of more than sixty two percent of the total population Thus, they are in overwhelming majority, while Pulaiyars are more than 21 percent

Table 3 2 The Caste composition in Village A

Caste	Number	Percentage
Mannadiyar	32	62 74
Chettiyar	4	7 84
Naidu	1	1 96
Vannar	3	5 88
Pulaiyar	11	21 56

However, they are the second largest population in the village The third largest population is of Chettiyars who are of more than 7 percent Rest 7 percent of the population is divided into two caste i e Naidu and Vannar It is interesting to note that the Village A is dominated by Mannadiyars, who had migrated two generations ago They only started the practice of farming and cultivation in this village after destroying the forest Generally, local population object to any kind of destruction of existing structure But to Mannadiyars the local population (of tribals) did not put up any resistance and Mannadiyars burnt the forest in order to make some area cultivable and livable for themselves Initially, the local people did not object to the settlements of the Mannadiyars However, in recent times there are some objections

raised by the native tribal group against Mannadiyars and other dominant castes on the initiation of a non-Governmental organisation called as "Society for Integrated Development of Tribal People" Pulaiyars the tribal caste, are the natives of this area This tribal group is dominated by all other caste groups Of this, other lower caste people are Vannar They are washermen by profession The rest of the population belong to other higher castes such as Chettiyar and Naidu

Land Holding

In village A half of the population are landless(see Table 3 3) Almost all Tribal residents are landless but for one resident Only one tribal household has some land that too of very meagre amount Among the land holders most of them are marginal and small farmers having land, less than 2 5 acres in possession It is interesting to note that only twenty five percent of the total population has land, more than 2 5 acres while, the rest has either no land or very meagre amount of land So the average land holding in the village is very low

Table 3 3 Land Holding Pattern of Village A

Land Holding	Number	Percentage
Landless	25	49 02
0 to 1 25 Acres	6	11 76
1 25 to 2 5 Acres	7	13 72
2 5 to 5 Acres	8	15 68
5 Acres and Above	5	9 8

3.1.2 Village B

Location

The Village B is located twenty kilometer away from the District Head Quarters and five kilometers away from Taluk Head Quarters (Nilakkottai) The village is surrounded by paddy and sorghum fields It is surrounded by villages in three directions

and contours in west The village is divided into some settlement areas The village residences are surrounded by paddy and sorghum fields, and some coconut trees Three sides of the village'B' are covered by different villages For example, in the eastern side it is connected with a village called Alagampatti While in the southern side its boundary is linked with a village called Michael Palayam In the north there is a village called Achipuram In the west of the village there is a metalled road connecting it with two towns, Chempatti and Nilakkottai This suggests that this village is very well connected In addition to this, in the east a road is connecting it with Madurai and Coimbatore cities which are known for temples and cotton industries, respectively Therefore, village 'B' sometimes becomes a good tourist resort

Facilities

Village 'B' is well connected with its Headquarters It has good transport facility, both passenger transport and goods transport There is electricity available for Agricultural and domestic purposes in village 'B' The street-light also are available in the village For drinking water, the residents had raised some funds and they have built a water tank in the village In this water reservoir (tank), water comes from a dam called Vaigai dam This way, the residents are able to solve their problem of drinking water and they are able to get clean potable water However, the village does not have drainage facility

The Health Sub Centre of the village is in Michael Palayam village which is one kilometer away from the village 'B' There is an additional Primary Health Centre about five kilometers away However, both the places are very well connected and transport facilities are easily available The village has few shops, some of them have medicines of common cure There is a co-operative shop in Michaelpalayam There is an elementary school up to fifth standard attached with nutritional meals centre in the village The village 'B' also has anganwadi In the anganwadi, the children below three years, young mothers and pregnant women are given nutritional food The pregnant women are also given some iron tablets by the Anganwadi The nutritional meals scheme of Government of Tamil Nadu provides free food in the schools under the midday meal scheme The village extension officers and Livestock

Inspectors regularly visits the village In addition to these facilities, village 'B' has a post office where a telephone is placed So whenever need arises, one can make use of the telephone for making emergency calls

Occupational Structure

In Table 3 4 the occupation details of village B is given In village B, more than half of the population is of Agricultural Labourers Other than Agricultural Labourers, there are tenants at will and marginal farmers, a few of them have land of their own It is interesting to note that more than eighty seven percent population is engaged in agricultural activities Out of the rest thirteen percent, a few are engaged in Government services and in miscellaneous jobs like tannery, Goldsmithy, petty shopkeeping etc

Table 3 4 The occupational structure of Village B

Occupational Categories	Number	Percentage
Farming	47	30 12
Agricultural Labourers	90	57 69
Trade and Business	7	4 48
Government Employees	4	2 56
Other Services	8	5 00

It would not be out of way to mention here that a few villagers are engaged in petty industrial occupations

Caste Composition

Table 3 5 describes the caste composition of village B The table indicates that 43 percent of the residents belong to caste Gaudar While the lowest caste, Chakkiliyar have the next highest position in terms of percentage i e more than twenty five percent The other 30 percent residents are distributed among Naiker, Achariyar Pardaram, Vannar, Thevar etc In village B, the dominant caste which takes most of

the major decisions are Gaudars They are basically hailing from Karnataka region and now they have settled in this village Gaudars have interest in farming and they still have influences of Kannada tradition

The next powerful caste in the village is Naiker They are relatively less in number in comparison to Gaudars Their major occupation is well digging They always migrate in summer and come back during rainy season Percentage wise Chakkiliyars have the second position in the village after Gaudars Chakkiliyar are the lowest caste in the village caste hierarchy However, their number is quite large and these people take care of farming as agricultural labour Therefore, they are very much needed in the village Acharıyar are the village artisans They are either Blacksmiths or Carpenters or Gold smiths Residents of Pandaram caste are the village - priests They are few in number, but they are always hot sought for either at the times of births, deaths, marriages or sickness Often, Pardaram Caste people are engaged in performing some ritual rites for taking care of some one ill health or bad Omen

Table 3 5 The Caste Structure in Village B

Caste	Number	Percentage
Gaudar	68	43 58
Naiker	30	19 23
Acharıyar	10	6 41
Thevar	1	0 64
Pardaram	3	1 92
Vannar	3	1 92
Chakkiliyar	40	25 64

Land Holding

Table 3 6 Land Holding Pattern in Village B

Land Holding	Number	Percentage
Landless	101	64 74
0 to 1 25 Acres	28	17 94
1 25 to 2 5 Acres	14	8 97
2 5 to 5 Acres	9	5 76
5 Acres and Above	4	2 56

Table 3 6 suggests that more than 64 percent residents do not have any land and it can be recalled that most of them work as farm - worker as mentioned in the table of occupational structure (see table 3 4)

Further, another 18 percent have very meagre amount of land i e 125 acres Only 18 percent residents have sizable land - holding Out of these 18 percent, only 2 50 percent has land more than 5 acres This distribution suggests that most of the residents of village 'B' either are landless or marginal farmers Therefore, they are engaged in occupation like farm labour, petty business trade or Government employment

After having seen the profile - attributes of sample villages, it is important that we should have a glance at our respondents' profile This section is providing information on socio-demographic profile of respondents

3.2 Socio Demographic Profile of Respondents

No study can be complete unless one is able to know the specific attributes of the population which one wants to study The critical role played by the socio-demographic background of any individual in the formation of his or her orientation is well acknowledged According to Ruth Benedict, most people are shaped to the form of

their culture because of the malleability of their original endowment They are plastic to the moulding force of society into which they are born(Benedict, 1934) In support of the above observation, Erich Fromm too has mentioned that man's nature, his passion and anxieties are a cultural product(Fromm 1947) The influence of age, academic qualification, income, occupation, family-setting, etc are major factors which are taken into account by social scientists for the purpose of understanding the cultural orientation of individuals and groups in a society

In the structural functional tradition, Talcott Parsons and other sociologists recoganise 'family' and community as basic subsystem of a society Family is the key institution for the purposes of socialisation of its members Socialisation is a process of "learning about self, the others and the society" (Slater,1967) It has been also called a technique of role-induction The process of role-induction has the following aspects

- the way in which an individual learns to play a given role and
- what motivates him/her to mould himself/herself in this manner!

The induction of individuals into various roles is facilitated by the process internalisation of roles Consequently, the process of internalisation of roles or role performance is entirely dependent upon the social background of the individuals It is often said that the orientations that an individual has towards different aspects of life large depends on his or her background experiences

This chapter introduces the social and demographic characteristics of respondents of the study In doing so we propose to focus on the differences in age education, socio-economic status based on the size of the land holding etc among the respondents

The previous section has already presented the profile of the sample villages giving the topography and demographic background of the universe In this chapter the profile of the respondents is discussed with specific reference to the following characteristics

1 Caste

2 Age

3 Occupation

4 Education

5 Income

6 Size of land-holding

Table 3 7 Caste Composition of respondents

Caste - categories	Village A	Village B	Total	Per cent
Mannadiyar	32		32	15 4
Gaudar		68	68	32 8
Chettiyar	4		4	1 93
Naidu	1		1	48
Thevar		1	1	48
Naiker		30	30	14 49
Acharıyar		11	11	5 31
Pandaram		3	3	1 44
Vannar	3	3	6	2 89
Chakkiliyar		40	40	19 32
Pulaiyar Tribe	11		11	5 31

The caste composition of the respondents presented in Table 3 7 shows that most of the respondents belonged to high castes such as Mannadiyars, Gaudar, Chettiyar, Naidu and Thevar Out of this total respondents 72 5 percent and 44 percent belong to high castes in village A and village B respectively An interesting observation from the table is found out that, there is no one belonging to middle caste in village A, whereas, in village B there are 28 per cent of respondents belonging to middle caste group In both the villages, only 27 per cent of the respondents belonged to low caste category The caste composition shows, that in Village A there are only high and low

caste respondents, while in village B respondents belonged to middle caste in addition to high caste and low caste categories

Table 3 8 Age Composition of respondents

Age (in years)	Village A	Village B	Total	Percentage
18 - 30	14	32	46	22 2
30 - 45	25	63	88	42 5
45 - 60	8	45	53	25 6
60 and above	4	16	20	9 6
Total	51	156	207	100

The age composition, as given Table 3 8 does not show any marked difference between the village A and village B As it is evident from the table that 27 percent of the respondents of village A and 20 percent respondents of village B are between 18 and 30 years of age It can also be seen from the Table that the majority of the respondents belonged to economically productive group i e between 18 years and 45 years, and only a few respondents were coming from old age category i e above 60 years

Table 3 9 Size Land Holding

Size of Land Holding	Village A	Village B	Total	Percentage
Landless	25	101	126	60 86
Less than 1 25 Acres	6	28	34	16 42
1 25 - 2 5 Acres	7	14	21	10 14
2 5 - 5 Acres	8	9	17	8 21
5 Acres and above	5	4	9	4 34
Total	51	156	207	100

Table 3 9 clearly shows the uneven distribution of land holding among the villagers In village A, majority of the respondents are owning the land, on the other hand in

village B majority of the respondents are not having any land in their possession Thus, in village A, 51 percent of the respondents are land owners and the rest (49 per cent) are landless While in village B, 70 percent of the respondents did not have any land and the rest (30 percent) have some land in possession Therefore, the respondents of village A were economically more well off than the respondents of village B

Table 3 10 Major Occupations of the Respondents

Occupation	Village A	Village B	Total	Percentage
Farming	26	47	73	35 26
Business		1	1	0 45
Govt Service		4	4	1 93
Industrial Labour		2	2	0 96
Services	4	5	9	4 34
Agricultural Labour	21	90	111	53 62
Others		7	7	3 3
Total	51	156	207	100

The occupational pattern shows presence of diversified nature of occupations among the respondents of both the villages Around 50 percent of the respondents of village A and around 30 per cent of the respondents of village B were engaged in farming on their own land since they were land owners While 40 per cent respondents of village A and 60 per cent respondents of village B were landless and therefore they worked as farm-workers This shows that the respondents of village A were more affluent and have better economic means than the respondents of village B It is interesting to note that a few respondents of both the villages were also engaged in service and in other activities This is contrary to the common notion that the rural folk are generally engaged only in agricultural activities as reported in many studies

Table 3 11 Education Level of Respondents

Education Levels	Village A	Village B	Total	Percentage
No Education	14	60	74	35 7
1 - 5 Years of Schooling (Primary Level)	16	61	77	37 19
6 - 10 Years of Schooling (Secondary Level)	17	31	48	23 18
11 and 12 Years of Schooling	2	3	5	2 41
University Educated (University)	2	1	3	1 44
Total	51	156	207	100

The educational level of the respondents of village A and village B shows significant divergence As shown in Table 3 11, 41 per cent of the respondents from village A have education up to secondary level or more While, only 22 percent of the respondents of village B have had education up to secondary level or more There are 27 5 percent of respondents from village A who have no formal education On the other hand there are 38 5 per cent of the respondents from village B who have no formal education In case of primary level of education, respondents of both the villages have more or less of equal percentage This description suggests that a large section of the total respondents i e 32 percent have not received any formal education This point is worth noting because Tamil Nadu State has claimed to achieve "total literacy" by the end of this decade that is in another four-five years which looks like a tall claim In addition to this, the table suggests that remote village (village 'A') has better educational status than the vicinity village (village 'B') inspite of all the easy accessibility to all the facilities

The average monthly income of the total respondents is Rs 414 However, there is a visible difference between the income distribution of the respondents of village

Table 3 12 Income Distribution of Respondents

Income per month (in Rupees)	Village A	Village B	Total	Percentage
Less than 300	5	89	94	45 41
300 - 600	20	53	73	34 78
600 - 1000	19	11	30	14 49
1000 - 2000	6	2	8	3 86
2000 - 3000	1	1	2	0 97
Total	51	156	207	100

Average income falls in this category

'A' and village 'B' Sixty per cent respondents of village A earn more than Rs 600 per month, while in village B there are only 9 percent respondents who fall in this category It is significant to note that only 10 percent respondents of village A have income less than the average income while in village B, 57 per cent respondents have shown income less than the average From this, it is clear that the respondents of village A are more affluent and more well off than the respondents of village B However, there are equal number of respondents falling in the average income category (see category of Rs 300 - 600)

With the help of the above discussions, it is clear that the respondents of the village A and village B are quite similar in their caste status, age composition and occupational background But there are significant differences between them in terms of their land holding pattern, education and income

Having discussed the social characteristics of the respondents, two important questions need to be pursued firstly, taking the data of education, income, occupation, age and caste background, how do the respondents of the village A and village B compare on a socio-economic status scale? Secondly, how are the socio economic status related to health status of the respondents differ?

To answer the above questions, it was decided to develop a SES scale so that a

proper frame-work was prepared for uniform comparison The procedure followed in constructing the socio economic status scale has already been dure followed in constructing the socio economic in details (See Chapter II) The Socio Economic Status Scale was developed with age, income, education, occupation and caste Based on this scale, the respondents from the village A and village B sub-samples were classified into low, middle and high categories

Table 3 13 Socio Economic Status of Respondents

SES Categories	Frequency	Percentage
Low	5	2 4
Middle	141	68 1
High	61	29 5
Total	207	100

Table 3 13 indicates that among the respondents, 68 per cent was in the "middle socio economic status category" and 30 percent of the respondents was in high socio economic status category While only 2 per cent of the respondents was in the low socio economic status category The findings suggest that an overwhelming majority of the respondents was in the middle SES category while only 30 percent was in high SES Category In low SES category, only 2 respondents have come (See Table 3 13)

The cross tabulation of socio economic status and health status is presented in Table 3 14 The scale of health status ranks is discussed in details in Chapter II

From Table 3 14, it is clear that more than 45 per cent of the respondents was placed in moderately healthy category, while, only 35 per cent of the respondents was in are highly healthy category In low health status category only 20 percent respondents have come in

From the Table 3 14 it is also clear that the health status of the respondents has increased with their socio economic status Therefore, a positive association is found between the socio economic status and the health status The statistical results also confirm the findings For example the contingency coefficient result shows

Table 3 14 Socio Economic Status and Health

Socio Economic Status	Health Status			
	Low	Moderate	High	Total (per cent)
Low	4	1		5 (2 4)
Middle	35	74	32	141 (68 1)
High		21	40	61 (29 5)
Total (per cent)	39 (18 8)	96 (46 4)	72 (34 8)	207 (100)

Chi square = 52 14 , df = 4 Contingency coefficient = 0 448

stronger association This observation indicate that the socio economic status must be influencing the health of the respondents

The forth coming chapter is devoted to present the impact of various variables of SES on health status

Chapter 4

Social Network and Health Care Decisions

A common question which always been of interest to understand as to how people make decisions It is well known that decisions are not made in isolation but they are the products of influence and confluence of social correlates Studies of some sociologists report that often decisions are made in consultation with their community members This understanding shifts the focus from individuals 'choice' to socially constructed patterns of decisions, including the consultation with others (Pescosolido, 1992) Therefore, one can conclude that health issues also have been decided in consultation with the community members Community is an interactive agency and it is a part of social network Social networks provide the mechanism through which individuals learn to handle their problematic issues Therefore, it will be of interest to understand the extent of the influence of social network on health decisions made by village population of Tamil Nadu

The social network theory suggests that the social relationships among individuals are based on exchange Each individual's feelings, ideology, emotions etc are exchanged with others in order to develop a strong bond among them The similar interactive exchanges are found in health network There are three major interactive subunits in the system of health- care - network, self, community and health-care

set-up The interaction among the above mentioned subunits results in the formation of a network in health decisions

Man is a decision maker However, his decisions are influenced by his/her advisors(community) or the available facilities(set-up) Keeping the above proposition in mind, the study was conducted to examine the extent of influence of community and health administration in the process of health care decisions

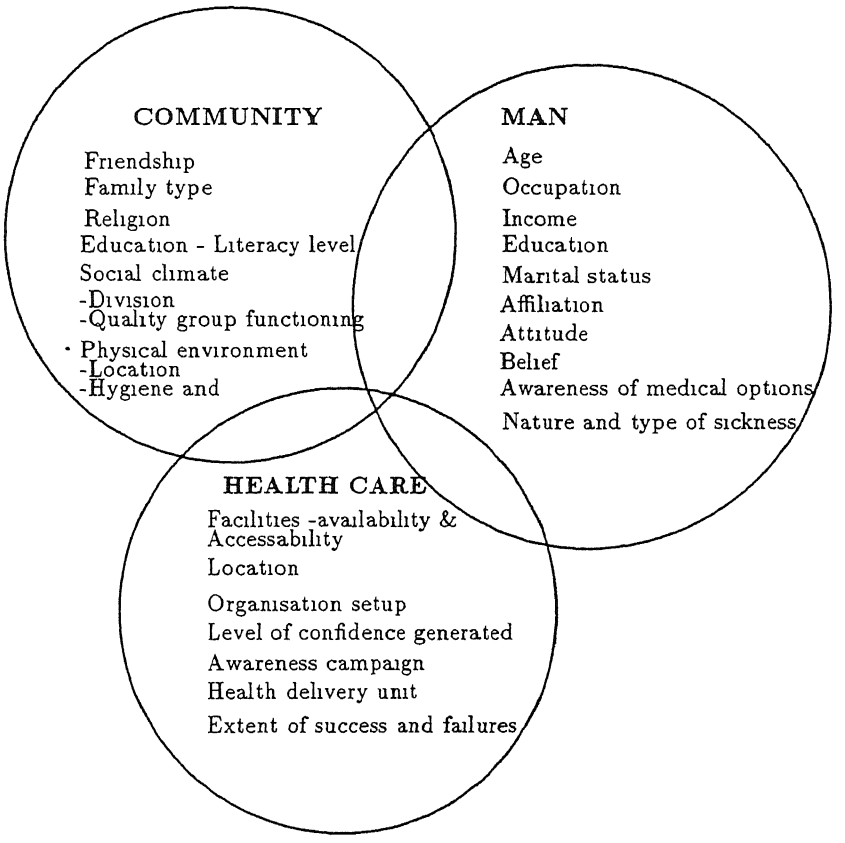


Figure 4 1 Health System

Figure 4 1 shows the three interactive units Man, Community, and Health Setup The unit of man consists of various elements like, age, occupation, income, education, marital status, affiliation, attitude, belief, awareness of medical options, natuie and types of sickness Likewise, Community subunit constitutes the elements like, friendship, family, religion, education, social climate, physical environment etc Health care

set-up subunit shows various constituents like, facilities, location, organisational set - up level of confidence generated, awareness campaign, delivery - units, and extent of success and failures of various programmes One may observe that all the units as well as the elements of the units show certain amount of influence on individuals' choices made for their health care However, one does not know the nature and extent of influence Do all variables/sub elements are equally influential? Or some may have greater influence than others ? While some may not have any influence at all? There may be a possibility that some elements are important at one point of time, while some may be in oblivion? Whether influences are culture specific or community specific? A host of questions can be raised The present exercise wishes to answer a few questions through empirical observation

The present study is an empirical exercise and it is attempted to identify the set of sub elements whichareimportant in health care decisions This study has adopted "Social network" perspective to understand the empirical finding Therefore, it would be beneficial that we have a quick glance at the theoretical perspectives of social network relationships before the analyses of the findings

4.1 Social Network Perspective

"Social Network" conveys the following set of ideas Individuals (or larger social units) are perceived as being "significantly" in direct contact with many others but not with all possible others Indirect contacts, through one or more intermediaries, may also be significant An individual may sometimes, if he or she makes an effort, succeed in making direct contact with someone to whom he or she has hitherto been linked only indirectly, indeed, this is one of the main ways in which individuals make new direct contacts Intermediaries may facilitate or obstruct this process of converting contacts from indirect to direct, or may endeavor to interpose themselves as a barrier or filter between individual and a direct contact Contacts between individuals may take the form of channels of communication, or of the flow of resources, or may manifest themselves merely the expression of attitudes and sentiments Whatever form the contact takes, it may affect the behaviour of the individual Since every individual

has her or his own set of contacts, the pattern of contacts as a whole affects the behaviour of the collectivity and is, simultaneously, an outcome of that behaviour

Most of the occurrences of the term "social network" in social science that are more than twenty years old, as well as most of the popular uses of the term, imply no more than the very general and quantified ideas just listed The ideas are non-controversial and can scarcely be regarded as testable propositions They constitute orienting notions and nothing more (Homans, 1967) On the other hand, social scientists in recent years have used "network" as a precise term and have developed definitions to generate testable, often quantified propositions Different practitioners have tried to propositionalise and quantify network notions in different ways More often, the social network relationships are understood as chain and interactive dependence The only measurement involved in counting the number of contacts impinging on each of a collection of individuals Indeed, the use of "personal network" as a technical term for an individual's direct contacts constitutes a striking case of what we might call "operationalisation by impoverishment" By confining attention to direct contacts, this definition eliminates the value of the term "network" as an orienting idea

The social network theory suggests the form of a network structure rather than the form of an organised group In the organised group, the component individuals make up of a large social whole with common aims, interdependent roles, and distinctive kind of sub-cultural practices In network formation on the other hand only some, not all, of the component individuals have social relationships with one another In a network the component external units do not make up larger social whole, they are not surrounded by a common boundary John Barnes used it as 'Each person is, as it were, in touch with a number of people, some of whom are directly in touch with each other and some of whom are not The image is of a set of points some of which are joined by lines The points of the image are people, or some times groups, and the lines indicate which people interact with each other (Barnes,1954) There are three network structures given in the figure 4 2 The points are either individuals or groups In figure 4 2 the capital alphabets represent groups and small alphabets represent individuals Part (i) is the representation of the interaction between the groups and

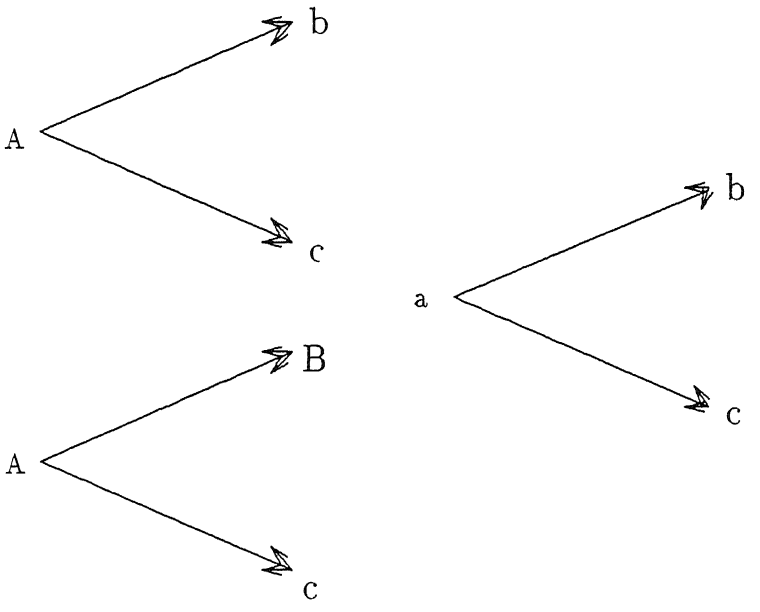


Figure 4 2 Social Network

the individuals, part(ii) is the representation of interaction between groups, and part (iii) is the representation of interaction among the individuals Such kind of network have following characteristics three or dimensions (a) the extent of link i e total and partial,(b) number of persons in a network i e finiteness or infiniteness and (c) boundedness i e within a boundary or without it

In his usage "partial" means certain kinds of links only, "finite" denotes a limited number of people, and "bounded" signifies that some persons exist who are not in the network

In addition to the above three dimensions, two more dimension have been added The dimension of "time" is suggested by Whitten and Wolfe and another dimension of social situation is added through A C Mayer's concept of "action set " However, one finds in situation of networking that the relationship might vary time to time and it might be situational relationship Therefore, one concludes that a social network can be consisting of all above mentioned dimensions

Since health is an outcome of social interaction in to a network relationship, it

is assumed that various constituents of the major components are influencing the decisions of individuals' health and health care The factors which are the bases of interaction can be classified into three major groups, (i) individuals' bio-social elements like age, income, attitude, liking etc and they are at the individual level (Self), (ii) the factors, which are common for the whole community such as, religiosity, caste affiliation, etc , and (iii) health care organisational set up which might initiate the interaction process

4.2 Analysis and Findings:

In the analysis two sets of relationships are established, (see chapter III & V) (a) the influence of attitudes of respondents (belonging to different SES) on health and (b) the role played by traditional beliefs in shaping the individuals' attitudes, toward their health

We have started with the assumptions that the respondents belonging to various socio economic orders make health decisions in a different manner We also assume the ritualistic beliefs affect the health care decisions Both the assumptions have been confirmed through findings

Table 4 1 presents the results of an analysis in which zero order correlations of Socio Economic variables, with health This table summarises the total effects of variables on each other The results show that the variables such as caste, religiosity, education and occupation have stronger relationship with health than the other two variables income and Age

For further analysis to study the relationship among these variables Stepwise Regression Analysis was conducted Table 4 2 reports the results of an analysis in which the three point measuring the health status was regressed on the Socio Economic Status variables and ritualism

It is clear from the regression coefficients that the Socio Economic variables and traditional beliefs have significant independent effects

Table 4 1 Simple Correlations among four Socio Economic variables and Health behaviour

	Caste	Income	Occupation	Education	Religiosity	Age
Health	64	15	31	- 04	61	07
Caste		36	53	19	78	- 04
Income			34	28	20	- 03
Occupation				29	43	03
Education					- 005	- 26
Ritualism						07
Age						

4.3 Cross correlation of Socio Economic Variables and Health.

A closer look at the standardised coefficients (Beta) invites three inferences First, the variable caste has a direct effect on the dependent variable through any of the other independent variables, and the magnitude of this effect is high (beta= 51) Thus, the respondents belonging to higher castes have greater access to the health facilities while respondents of lower castes have less access Hence, the impact of caste status on health status is positive Secondly, religiosity which is reflected in a disciplined way of living, again shows a strong relationship(Beta= 20) This result suggests that the respondents who reported to be strictly following the routine way of living and leading disciplined life, which was a byproduct of ritualistic behaviour could maintain their health in a better way than those who did not have a disciplined way of life For example, the respondents who are highly religious were following some of the strict routines, such as taking bath twice a days, while wash their feet and hands as soon as they come back home, keep the home environment clean etc (see Chapter V for more details) Further, the highly religious respondents were normally influencing their friends and close relative in following of similar kind of disciplined way of living

Table 4 2 Stepwise Regression of Socio Economic Variables and Health

Independent Variable	Unstandardized Coefficients	Standardized/ Coefficients
Constant	1 37	
	(9 049)	
Caste	42	51
	(5 89)	
Education	- 21	- 14
	(-2 72)	
Religiosity	19	20
	(2 33)	

It is an outcome of the social networking

The interesting inference based on the statistical results(beta = -0 14) value is the inverse relationship between the educational status and health The inverse relationship is due to the prevalence of unemployment among highly educated youths Since they are not able to get jobs which can commensurate with their knowledge and training, they have to migrate to nearby urban localities to get a job Thus, they are exposed to an environment wherefrom they were likely to pick up bad habits which were harmful for their health, such as, smoking, alcohol consumption etc This leads to different kinds of diseases amongst them It is also observed that, the intoxicants are very commonly used by the educated youths It was observed that the educated respondents did not pay attention to the practices like early morning bath, going for a morning stroll, etc , which were otherwise commonly followed by the respondents who were staying in the village

Further, Table 4 1 shows that each unit comprises of various variables but they are not very influential It is confirmed by the statistical results also (kindly refer Table 4 1)

While Table 4 2 shows that in addition to education a number of variables have

very strong effect on health behaviour of the respondents, they are age, income, affiliation, occupation, discipline in life- style, belief, etc In following paragraph some further discussions are given to explain the influence of those variables

Age

Age composition of respondents consisted of two categories, they are of independents and dependents The persons who are between the age group of 15 and 60 are termed as independents They are in the working group category Since, they are economically independent, they make decisions for themselves The children up to 15 years of age and old people above 60 years are placed in the category of dependents Their health decisions are generally made by their care - takers, since they do not have an income of their own

Income

There is an association between income and health Even though income does not show strong statistical relationship with health, the respondents' responses have depicted relationship Income plays a vital role in maintaining health Majority of the higher income group respondents are economically well off, since they are the land owners also Therefore, higher income group respondents in the event of health problem could afford to provide good care to their patients They could afford to hire vehicles to take their wards to nearby hospitals for treatment On the other hand, most of the landless labourers, who did not have much income either to spend money on costly medicines or take them to nearby hospitals for immediate relief Consequently, in the event of need, they can only afford to take their patients either to the local quacks, or the missionary hospitals where they can get inexpensive treatments Mr Selvam, of village A was having some stomach disorder and he was advised to go to the District Hospital for treatment the relatives could not afford to hire a vehicle to take him to the District Hospital which was 40 kms away His simple stomach disorder got deteriorated to such an extent that he developed ulcer Lateron he had to borrow some money for getting the operation done This incident suggests that how important is the financial status If Mr Selvan would have got some on may while he had simple stomach disorder, he would have gone to hospital and he would

have saved himself from the injury of the operation

Affiliation

Affiliations are of various kinds It can be of friendship, neighborhood, caste, family, etc Among the respondents it was observed that they constantly consulted their affiliated members in the matter of crisis For example, in village A, the respondents had formed some play groups and clubs where they very regularly meet Whenever some critical decisions were made, they were made by the group not by individuals For example, Mr Viswanathan a respondent of village A was sick Mr Rajendian, his friend came to know of his sickness Mr Rajendran met Mr Viswanathan and narrated his observations and experiences regarding hospital care Mr Rajendran told him that homeopathic doctor (of the vicinity) was very easily available and he normally took good care of his patients Thus, Mr Rajendran advised his friend, Mr Viswanathan to go to the homeopath of the locality And Mr Viswanathan did so He went for homeopathic treatment while his employer objected to it on the grounds that homeopathy would take more time and it may require more money as well However, Mr Viswanathan did not change his decisions and went for homeopathic treatment only, accepting his close friend's advice ignoring his employers' objection This is not a unique case Often it is observed that affiliations like friendship, neighborhood - relationships, influence this type of choices This boils down to the fact, that units of man and community are in very close correspondence with relation to the health-care decisions made by the respondents of the present study

Caste Status:

Caste status of respondents had its own influence on the health care decisions It is commonly observed among the respondents that a strong relationship existed among different caste status groups

The Higher caste respondents were dominant group of persons having easy access to all kinds of village facilities, while the middle and lower caste respondents were subordinated ones having less access to those facilities, such as potable water facilities, nutritional diets, medical aids etc Consequently, the lower caste persons were more, vulnerable in terms of inflicting diseases and in having poor health

Education.

Result shows that education have a strong association with health The negative association between education and health is also shown but that was only for the respondents who were highly educated and only for them who have picked up bad habits like smoking, consuming liquors, etc It was observed that the use of intoxicant material and consumption of liquor were very commonly found among the educated respondents of especially among those who were coming from affluent groups While the poor respondents who were less educated and they did not go out of the village were keeping good health Thus, this finding negates the assumption that educated persons would have good health because they can take good care of their health

Occupation

Occupation is an important factor responsible for the health care of individuals There are three major categories of occupations among the respondents (kindly refer Chapter II), they were, higher occupations, middle level and lower level occupational categories The occupational hazards found among the respondents of lower level occupation categories who were engaged in agriculture work These occupational hazards were not coming in the scenario of health care by choice but as a matter of force However, occupation and health care choices had shown some link among the respondents as shown in Table 4 1 (a) Since, statistically a weak relationship is observed

From the above discussion it is clear that socio economic variables, and religiosity influences the health of an individual , in the process of interaction In the process of interaction in a social network either an individual or a group influence the decision of another individual by means of various factors which decides the health-issues For example, in case of volley ball club, the friends are influencing the decisions Same way groups such as voluntary organisations, including youth clubs, health organisations etc are influencing the health decisions

4.4 Conclusion:

A classic problem common to sociology of management revolves around how people make decisions Some recent studies have shown the need of some rational action strategy for health care helps (Pescosolido, 1991) The above discussion presented in this paper had shown the influence of social correlates or social networks on individuals' decisions related to their medical helps This orientation rests on the fundamental principle of social interaction which had the basis of social life and social networks They provided the mechanism (interaction) through which individuals learn the techniques of handling their problematic issues This approach shifts the focus from individuals' self decisions to socially constructed patterns of decisions The findings make a case for reviewing theoretical approaches to decision-making and they provide some information essential to a theoretical exposition of social network relationships The above findings support the utility of social network approach for understanding the dynamics of rural health care choices made by the respondents

Chapter 5

Religiosity and Health

5.1 Introduction

In the last chapter it was stated that religiosity had a strong relationship with health (refer Tables 4 1 and 4 2) Hence, this chapter is primarily focusing its attention on the various aspects of religiosity and health

It is observed that the population of village India, to a large extent, is influenced by religious beliefs For cultural formation of rural population, religiosity is found to be a very important factor in guiding individual's daily routine Some studies have already pointed out some relationship between moral conduct of individuals and health (Cartstairs, 1965, Hasan, 1967) The studies reported that the roots of illness extend into realm of human conduct and cosmic purposes Further, these studies have mentioned that villagers did not pay attention on their health care but they do care to follow certain practices in a very rigid manner For example, the villagers are in habit of taking early morning walk either for a dip in the holy rivers or toilet purposes, following of certain kind of restrictive diet on certain days, keeping fast on certain specified days etc All of these hygienic and health practices are linked with the aspects of religiosity Likewise, the habit of bare-footed trekking and of smoking from the same hobble-bubble are some of the inhygienic traditional practices directly affecting the health (Carstairs, 1965, Hasan, 1967) These habits are known

as religious practice and they have roots in the frame-work of religion Therefore let us examine the effect of religious practices and rituals as aspects of religiosity on health in the coming paragraphs

5.2 Religion

Sociological definitions of religion take two main forms substantive and functional Substantive definition defines religion as a belief and institution directed towards deities or other superhuman beings such as ancestors or nature - spirits (Tylor, 1871) Functional definition of religion arose principally from Durkheim's rejection of the Tylorian approach According to Dunkheim's religion is a binding force and it is always needed for balanced growth of a society In sociological tradition, religion is considered as an institutionalised system of symbols, belief values, and practices Thus, beliefs and rituals are the main components of any religion

In sociological tradition. religion is seen to be in two forms animism and naturism Animism is the belief in spirits Edward B Tylor believed this as the earliest form of religion He argued that animism derives from man's attempt to answer questions on the relationship between life and death Tylor suggested that religion, in the form of animism originated to satisfy man's intellectual nature to meet his need to understand the events of death, dreams and visions (Tylor, 1970) On the other hand, proponents of naturism believed that the forces of nature have some supernatural power Contradicting Tylor's arguments, Malinowski put forward that naturism was the earliest form of religion According to him, naturism arose from man's experience of nature, in particular the effect of nature upon man's emotions Nature contained surprises terrors, marvels and miracles such as volcanoes, thunder and lightning Awed by the power and wonder of nature, the primitive man transformed abstract forces into personal agents The force of the wind became the spirit of the wind, the power of the sun became the spirit of the sun (Malinowski, 1954) Animism seeks the origin of religion in man's intellectual needs, while naturism seeks it in fullfilment of man's emotional needs In the context with the rural masses of

India, one finds the peculiar blend of animism as as well as naturism

To some extent Durkheim in his book 'The Elementary Forms of Religion' has supported the blend of natural power and the supernatural beliefs He said, that all societies divided the religious acts in to "the sacred" and the "the profane" Sacred things are considered to be superior in dignity and power to profane(non-sacred) things According to Durkheim, religious beliefs are neither to fullfil intellectual needs nor emotional as suggested by Tylor and Malinoski but religious beliefs and practices are needed for the survival of a man Religion in all forms and types have functional use in a man's life and therefore they were always present

All human beings believe in supernatural power That is there is a power beyond human-power and knowledge It is true even in the case of health and illness People believe that one is healthy and other is not because of the effect of some supernatural forces There are instances among the rural masses where illnesses are associated with God Diseases like small pox, chicken pox, measles and cholera are generally associated with a particular God or Goddess or deities as well as the power of natural elements like certain kind of wind pressure, sunlight and Neem tree In rural India, people believe that the health problems arise due to the sins committed in last birth They generally associate the outbreak of epidemics with the non performance of certain rituals by the population Likewise, respondents of the study believed certain diseases can never be cured with any amount of medical aids and they can only be cured through the help of divine power which can be aroused by offering, prayers, chanting of 'mantras' etc they did mention to the investigator that dreaded diseases like small-pox, plague, cholera have cures in divine offerings and religious rituals

5.3 Rituals

The Latin 'Ritus' from which the term ritual is derived means 'custom', a notion which has misled certain sociologists to believe that ritual was the routine of an organised religion There is, however, no denying that without ritual there cannot be an organised religion, but this does not necessarily mean that all rituals are religious

There are many rituals which exclusively have social character, not to speak of the magical and what we would like to call the metaphysical rites, none of which can be confused with the religious ones Certain rites are as much a part of the daily routine of the individual and hence as much as eating, drinking and the other odd chores of domestic life Unless the necessitous is defined strictly in physiological terms without any sociological admixture, rites cannot be place in the category of the extra-necessitous And if the term is defined in this manner, not only rites but several other practices too, will have to be included in the other category The popular distinction between the sacred and the profane, again does not seem to be a sound basis for distinguishing rituals from ordinary practices It is in fact the ritual 'touch' which makes certain practices sacred, not that an act becomes ritual because it happens to possess a sacred character The objects and beliefs treated as sacred are sacred only because they are endowed with a ritual-value

Rituals are often understood as a form of symbolic action Sometimes symbolic actions differ from the ordinary ones However, the distinctive characteristic of symbolic actions is that they are not governed by the laws of logic which normally govern the other ordinary action

In the back-drop of the above discussion, one can appreciate the importance of ritualistic action with in the frame-reference of religion In Chapter II, we have described the measurement of religiosity Religiosity can be measured by performance of various kinds of ritualistic actions On the basis of the observations during the field work, the following items as indicators to measure the levels of religiosity and levels of health were developed

To determine the degree or extent of the respondent's religiosity the following four indicators were selected

1 Visit to place of worship

2 Celebration of religious ceremonies

3 Performance of rituals and attitude towards it

4 Restriction on dietary practices

Respondents who visited to the places of worship daily were assigned 3 points, the respondents who visited to places of worship once in a week were assigned 2 points, and the respondents who visited to places of worship once in a month or occasionally were assigned 1 point For the questions on religious ceremonies and rituals, 1 point to each positive response and zero value for negative responses were given For the respondents who kept fast and maintained restriction on diet at least once in a week were assigned 3 points, the respondents who kept fast once in a month and some restrictions on diet were assigned 2 points, and who kept fast once in a year or occasionally and who maintained occasional restriction on diet on some specific days were assigned 1 point The total score ranged from 2 to 8 Those who secured 2 points were placed in 'Less religious' category, those who scored 3 to 5 points were place in 'Moderately religious' category and those who secured 6 to 8 points were placed in 'highly religious' category Thus, the scale was divided into three major categories less religious, moderately religious, and highly religious

Likewise, to assess the extent of 'good health' the following five indicators were used

1 Incidence of sickness,

2 use of physical health measures,

3 paying attention towards personal hygiene,and getting help from family members

4 consumption pattern, and

5 sanitation

For all questions 1 point to each positive response and zero point to each negative response were assigned The aspect of sickness was inclusive of frequency, type and duration

The total score ranged from 0 to 5 Those who secured upto 1 were placed in 'less healthy' category, those who scored between 2 and 3 points were placed in 'moderately

healthy category, and those who secured 4 and 5 points were placed in 'highly healthy' category Thus, the scale of health-status was divided into three major categories less healthy, moderately healthy and highly healthy

Using the above two measurements, we arrived at three levels of health-status (high, moderate and low) and three levels of religiosity as presented in Table 5 1

Table 5 1 Religiosity And Health

	RELIGIOSITY			
HEALTH	LESS	MODERATE	HIGH	TOTAL (per cent)
LESS	11	28		39 (18 8)
MODERATE	15	24	57	96 (46 4)
HIGH		3	69	72 (34 8)
TOTAL (per cent)	26 (12 6)	55 (26 6)	126 (60 9)	207 (100)

X = 99 306, df = 4, $p < 0$ 01 Pearson's r = 0 6117

The Table 5 1 suggests the frequency distribution of respondents into various categories of health status and religiosity The table shows that religiosity and health-status are in correspondence with each other It means highly healthy respondents are the highly religious persons It shows, that the majority of respondents who are having good health (ie 69 out of 126) are termed as highly religious persons too Likewise, those who have scored low on scale of religiosity, have scored low on health scale too (i e , 11/26) However, it is worthnoting that a very low percentage of the total respondents fall in the category of low health status (i e , only 26 respondents) Out of these 26 cases, only 11 are in the category of low health status This finding suggest that most of the respondents were very religious and therefore, they were

following the traditional practices

Some of the statistical results confirms the above finding For example, the Chi Square test score shows that, there is a significant relationship between ($p < 0\ 01$)

5.4 Religiosity and Health Status

In addition to the above results, the coefficient of correlation also confirms (r = 0 6117) a significant relationship

The respondents who are placed into the category of highly religious are visiting the places of worship once in a day They used to perform certain daily routine practices as sacred functions or rituals, such as taking bath before going to a temple, use of sandal mark on forehead, smearing of sacred ashes (made of burnt cow dung cakes) on the fore head, carrying flowers and camphor sticks etc Most often highly religious respondents kept fast for a day once in a week along with certain kind of restrictive diets on rest of the days They normally consume vegetarian diet consisting of items like curd, fresh vegetables unpolished rice, seasonal fruits, coconut, etc Generally, their food was served on banana-leaves Their practices suggested inoculation of certain amount of discipline and regularity in their way of living which in turn was able to provide a mechanism of maintaining good health To some extent this assumption got confirmed through the answer pattern of respondents (refer Table 4 1 and 4 2 in Chapter IV)

After having a discussion on ritualistic practices as routine action, it would be useful if we can have a look at the offerings performed by the respondents Each respondent was asked whether they are offering On response to the question, all respondent excepting two respondents performed offerings

Table 5 2 shows 205 respondents perform offerings in the form of animals, pongal, hair etc for common cures It is interesting to observe that almost all the respondents performed offering either for common cure or tangible benefits excepting 2 respondents who mentioned that they did not believe in offerings Normally these offerings

Table 5 2 Kinds of Offerings

Kinds of Offering	Number
Goat	192
Pongal	193
Money	115
Hair	4

were made in the form of promises at the time of sickness and as soon as the sick person becomes healthy, the promises of offering were fullfilled in front of the deities

Table 5 3 Socio Economic Status And Religiosity

SOCIO ECONOMIC STATUS	RELIGIOSITY			
	LESS	MODERATE	HIGH	TOTAL (per cent)
LOW	2	3		5 (2 4)
MIDDLE	23	44	74	141 (68 1)
HIGH	1	8	52	61 (29 5)
TOTAL (per cent)	26 (12 6)	55 (26 6)	126 (60 9)	207 (100)

Table 5 3 shows that there exists a positive relationship between socio economic status and religiosity As we have seen earlier (Chapter III, Table 3 13), a majority of respondents belonged to the middle SES Category Among the middle SES Category members a majority of the respondents are placed into highly religious group It is the same in the High SES Category From Table 5 3 it is clear that the religiosity is increasing with the socio economic status The statistical analysis also confirms

it (contingency coefficient = 0 34) Table 5 3 suggests that the respondents who belonged to high SES categories are highly religious and low SES respondents are less religious It shows that the religiosity increases with SES

For discussion of SES, kindly recall the matter of Chapter V where an association between socio-economic variables and health have already been shown It is interesting to suggest that some meaningful relationship have been observed among the socio-economic variables of respondents and the various forms of ritualistic practices of the respondents The variables influencing the health behaviour are caste affiliation, age, income, educational achievements, the practices and health

Table 5 4 Caste Affiliation and Respondents' Religiosity

Categories of Religiosity	Caste Categories			
	Low	Moderate	High	Total
Low	39	0	0	39
(percent)	(67 2)	(0)	(0)	
Moderate	19	40	37	96
(percent)	(32 7)	(93 02)	(34 9)	
High	0	3	69	72
(percent)	(0)	(6 9)	(65 09)	
Total	58	43	106	207
(percent)	(100)	(100)	(100)	

Chi Square = 183 42 , df = 4 , $p < 0$ 01 Pearson's r = 0 7892

Table 5 4 shows a positive relationship between caste status and the religious status It means that the respondents coming from low caste hierarchy have scored low in ritualistic performances Likewise, the higher caste respondents have shown high kind of religiosity in ritual performance

Respondents were categorized into three major categories of religiosity based on their religious activities such as diet, fasting, offering etc (see Chapter II) Likewise,

the respondents were composed of various caste groups based on their status placement in caste hierarchy such as high caste, middle caste and low caste (see chapter II) In the Low Caste Category there were 39 respondents who were also placed into the less ritualistic category (see Col 1 of 5 1) because they scored low on the composite scale of ritualistic behaviour It suggests that there was complete congruity among the respondents of low category Respondents coming from low caste groups did not believe in rigidity of ritualistic action Hence, they scored low on ritualistic scale While 19 respondents were placed into "moderately religious" category Table 5 4 further suggests that respondents belonging to low caste category either have been placed into low religious or moderately religious groups It is interesting to point out that none of the respondents of the low caste category were placed in 'highly religious' category Table 5 4 further denotes that almost all the high caste respondents were placed into highly religious or moderately religious groups (See Col 3 and row 3) while none of the high caste respondents were found in the less religious category (see Col 3) The statistical results i e the Chi square test score also confirms the above hypothesis by showing significant relationship between different caste categories and the level of religiosity (Chi Square = 183 42 $p < 0\ 01$) The differences are in the expected direction The coefficient of correlation result (r=0 789) also confirms the hypothesis After some probing, we learnt that many rituals were commonly followed in a very religious manner for some tangible benefits For example, once Muthu a respondent from Mannadiyar caste was needed five thousand rupees for purchasing a pair of cows For this he promised for offering his hairs to Lord Murugan of Palani, in case of getting the money After a week or so,his friend who was working in another farm had sent him the required amount This kind of offerings were common among the higher caste respondents As soon as Muthu got the money he wanted,he offered his hair

The Table 5 5 denotes that the health status of different age categories of the respondents It shows some kind of uniform distribution in different levels of health status However, it is interesting to note that the respondents belonging to young age categories are also keeping the health status matching to the old age categories One

Table 5 5 Religiosity And Health Among Different Age Groups

	AGE CATEGORIES											
	YOUNG				MIDDLE				OLD			
RELIGIOSITY	L	M	H	T (%)	L	M	H	T (%)	L	M	H	T (%)
HEALTH LESS	3	4		7 (15 2)	6	17		23 (26 1)	2	7		9 (12 3)
MODERATE	3	7	14	24 (52 2)	8	8	22	38 (43 2)	4	9	21	34 (46 6)
HIGH		1	14	15 (32 6)			27	27 (30 7)		2	28	30 (41)
TOTAL (per cent)	6 (13)	12 (26)	28 (60)	46 (100)	14 (16)	25 (28)	49 (56)	88 (100)	6 (8 2)	18 (24 7)	49 (67)	73 (100)

M - Moderate H - High T - Total

would assume that young persons would be healthier than the old persons However, this assumption is completely believed with the findings Further, it is observed that the older respondents were having more disciplined life than younger respondents It is quite possible that the differences in health status may be taking place because of the disciplined routine life

Table 5 6 Religiosity And Health Among Different Educational Categories

	EDUCATION CATEGORIES											
	LOW				MIDDLE				HIGH			
RELIGIOSITY	L	M	H	T (%)	L	M	H	T (%)	L	M	H	T (%)
HEALTH LESS	7	20		27 (17 9)	4	8		12 (22 6)				
MODERATE	10	18	44	72 (47 7)	5	6	11	22 (41 5)			2	2 (66 7)
HIGH		1	51	52 (34 4)		2	17	19 (35 8)			1	1 (33 5)
TOTAL (per cent)	17 (11 2)	39 (25 8)	95 (63)	151 (100)	9 (17)	16 (30)	28 (52 8)	53 (100)			3 (100)	3 (100)

L - Less M - Moderately H - Highly

Table 5 6 denotes the health status of different educational categories of the re-

spondents It shows some kind of uniform distribution in different levels of health status However, it is interesting to note that the respondents belonging to lower level of education categories were also keeping the health matching to the highly educated respondents One would assume that highly educated persons should be healthier than the less educated respondents However, this assumption is not found true Further, it is observed that the less educated respondents were having more disciplined life than highly educated respondents The highly educated respondents migrate to urban areas due to unemployment, because of that they pick up bad habits such as smoking, consuming liquors etc Therefore, the highly educated respondents could not follow the routines regularly Hence, the relationship between health and religiosity among different educational category is clearly seen

Based on respondents' description of ritual practices, some characteristic of rituals have been observed They are

- Tangibility in rituals performed for tangible gains attainment of tangible objects like wealth success, physical, power political gains etc were the major motives related with certain kind of distribution of money/gift etc Once Murugan appeared in the Secondary School Examination, he prayed to Lord Murugan that if he passes the examination, he will offer a coconut When he succeeded in the examination he offered it Likewise, rituals are performed for tangible benefits

- Supernatural complexion of rituals Ritual performances are part of the religious system for attaining salvation in some form Sometimes their effectiveness is presumed to depend upon the "will" of a supernatural being, thus, when respondents speak of prayer or supplication, they imply that the supernatural being who is addressed may fullfil the wishes of the petitioner In some rituals, however, the performance is automatically effective provided that it is carried out according to certain prescriptions For example, in case of spread epidemic diseases like small-pox, measles (a variety of viral disease) In the study villages, it was observed that, whenever a child is ill of chicken pox the members of the

family worshipping the child by saying The Goddess has gone into the child

- Rituals as moral conduct According to Durkheim in all modes of life, relating to serious acts such as happiness, grief, sufferings, etc one is supposed to perform certain prescribed rituals For example, thanks giving celebrations, death rites, funeral-procession etc These rituals are brought in practice form to inoculcate some moral order and discipline Among the respondents of the study it was a common practice that whenever there was a happy occasion like the birth of a child, or a marriage, they performed some rituals to celebrate the happiness as a symbol of thanks giving Similarly, when a person died, the villagers performed rituals on the second day which they call 'Paal Uthuthal' (milk giving ceremony) This ceremony was performed to show certain amount of respect towards the departed soul

- Transcendental aspect of rituals Ritual imposes a transcendental obligation - an obligation which does not stand or sanctions but enforces itself spontaneously Its impact on human mind may be characterised in metaphysical terms as awesome, faith or devotion in contradiction to the psychological 'appeal' of dynamic morality Love, compassion, charity and loyalty, the tenets of the dynamic morality are the universal principles of human existence In conforming to these, man simply obeys the law of his nature, he will cease to be a human being if he refuses to abide by them

An overview of some of the above discussion it can be suggested that health is as much a socio-cultural phenomenon as it is a biological explanation Religious values such as deeds of the past, attributing to sins committed by people and consequent of wraths of gods and goddesses and treatment sought through magico- religious practices, are indicators of the influence of our tradition and cultural life With the spread of education, exposure to mass media, urbanizing and industrializing influences resulting in occupational and spatial mobility and economic well being, choice of people to accept modern medicine over folk medicine has increased Even villagers or tribal folks look forward to modern medicine for relief from pain, sufferings or

physical ailments Medicine, whether folk or modern has a dual nature Irrespective of the technological level of a society, people still would lend support to the physicians efforts with their prayers and propitiation of gods and goddesses This mix of scientific temper and faith healing in medicine needs to be understood in the context and situation in which it operates It may be only making tall claims that modern medicine has stalked death It has only postponed death but at the same time, the scientific development has increased the "at risk factor" for the health of man In other words, the life span of man has increased but his rate of becoming unhealthy has increased many fold Indian villagers in this modern world still wants to try out various systems of medicine and when they feel dissatisfied with one, they are inclined to try their hand on another, till they are forced to entrust themselves to the folk medicine which is close to their cultural milieu

Chapter 6

Organization of Indian Health Bureaucracy and its Delivery System

6.1 Introduction:

The aim of this chapter is to probe into the structure and functioning of health bureaucracy in India with specific reference to rural health bureaucracy of Tamil Nadu State Since the discussions require to deal with bureaucratic elements, therefore it would not be out of way to have a glance at the concept of ' bureaucracy' Bureaucracy is defined as "a hierarchical division of staff who act on formal assignments" - Gouldner(1954) This definition suggests five specific dimensions of bureaucracy namely (i) hieracrchical structure (ii) nature of work and progress (iii) procedural devices (iv) decision making and (v) procedural bottlenecks have ben considered in this order to understand the functioning of bureaucracy These factors are particularly relevant to the understanding of bureaucratic functioning as the previous studies have indicated that the magnitude of these attributes varies from one organization to another (Hall, Peabody, Meyer)1 The functional complexities of any bureaucratic system largely depends upon the combination of these attributes (Bennis)2

Hall, for example, observed that certain organisational activities are related to one or more of the above mentioned dimensions3 The attributes like division of labour, heierarchical structure and the type of decision making have been found to be closely linked with one another Similarly Lindblom concludes that the selection of goals and appropriate means are generally interwoven Good policy can be formulated when decision makers find themselves in agreement

As regards planning and coordination, Meyer's findings have revealed that the nature of work and supervisory positions determine the level of coordination and nature of planning 5 Prasad and Singhi have noted that complexity of rules and procedures adversely affect bureaucratic efficiency 6

All these studies are essentially centreed around Weber's model which presumes that these attributes are ideal for the functioing of any organization? Within this theoretical perspective the present analysis centres around a very broad query i e whether these attributes have implications for aspects like decision making and overall organisational functioning If so, then what is the functioning of the organizational set up under study

The organizational functioning is being analysed here with a view to identify those attributes which influence organizational effectiveness and decision making

Weber's model of bureaucracy characterised as an 'ideal typical model suggested the desired features of a bureaucratic structure on the basis of number of attributes Max Weber, the master theoretician, found four major attributes of bureaucracy that marked it out for its advantages They are efficiency, predictability, impersonality and speed As an ideal type, it could possess all those attributes and perhaps more, at one point of time or all times However , in sociological analysis of functioning of bureaucracy in transitional society like ours shows that no real society can have all attributes at one point of time The ideal type attributes can work as a goal and one can desire to achieve them by putting proper efforts However, it may not possible for a bureaucracy to have all of them at one point of time

Further, Weber suggested some desirable elements of a bureaucracy, such as

- *hierarchical stucture* the lower officials are supposed to be supervised by the higher officials and there has to be a ring like structure in any bureaucratic organisation,
- nature of work and progress,
- procedural devises for recruitment of functionaries as well as policy - decisions,
- decision - making and maintenance of all records,
- procedural of bottlenecks and their solution

The above features suggest that in a bureaucratic organization, there has to be some definite rules and procedures, and all officials of different levels are controlled by those rules and procedures Further, it has been suggested that organization cannot perform its functions properly unless assignees are strictly appointed based on their merit and efficiency Hierarchical structure needed to be maintained to provide proper supervision of lower staff by higher ones The appointments and promotions have to be made on the basis of technical competence Weber had given lots of importance to the process of selection of bureau- crats and had given some basic principles for their role-perform- ance

According to Weber each and every person working in an administration has to obey the officials who are superior to him/her Also, the decisions made at the lower level have to be ratified by the superior officials For Weber, an efficient administration must be able to have some schemes of distinct distribution of power allocation to different levels However, it was observed in number of studies that the above scheme may create certain amount of malfunctioning (Bennis 1972)

6.2 The Organizational Structure of National Health Organization:

India has a parliamentary system of government with a President, a Council of Ministers (Cabinet), 'a House of the people' (Lok Sabha) and a House of the States (Rajya

Sabha) Administratively, the country is divided into 25 states and 7 Union Territories In all, India is comprising of 408 districts(Most of them having a population between 1 25 to 1 5 million), which are further divided into smaller Tehsil or Taluks and Blocks each with population of 80,000 to 1,00 000 for taking care of development programs

Under constitutional provision, health services is mainly the responsibility of state governments The responsibility of the Union Government is only confined to international health, food quarantine, inter-state quarantine, research, and promotion of special studies and institutions As the Union Government is also directly responsible for administration of the union territories, it is also directly responsible for running the health services in those territories

The Union Government has established the Central Health Council, consisting of the Union Minister of Health and all the health ministers of the state governments(see figure 6 1) The council is, theoretically, an advisory body, but in practice it has assumed the form of supreme body of policy making for health with the Union Health Minister playing a dominant role

Figure 6 1 suggests that the Union Minister of Health and Family Welfare holds the key responsibility for his ministry in the union Cabinet headed by the Prime Minister The Union Minister is often assisted by one or more Ministers of State and/or Deputy Minister

The Union Minister of Health has a secretariat which is known as Ministry of Health and Family Welfare It is headed by a secretary who is an administrator, usually belonging to the Indian Administrative Service (IAS) cadre The Secretary happens to belong to a non-technical service and therefore he lacks in specialised kind of health training(medical) Therefore, he is a generalist administrator Even though the secretary of health is not trained in technical aspects of health administration, it is felt that he possesses the political and social skills to assist the Minister to discharge his function in the cabinet and in the parliament as the political head of the Ministry (see figure 6 2)

The secretariat has a directorate of health services with specialists The direc-

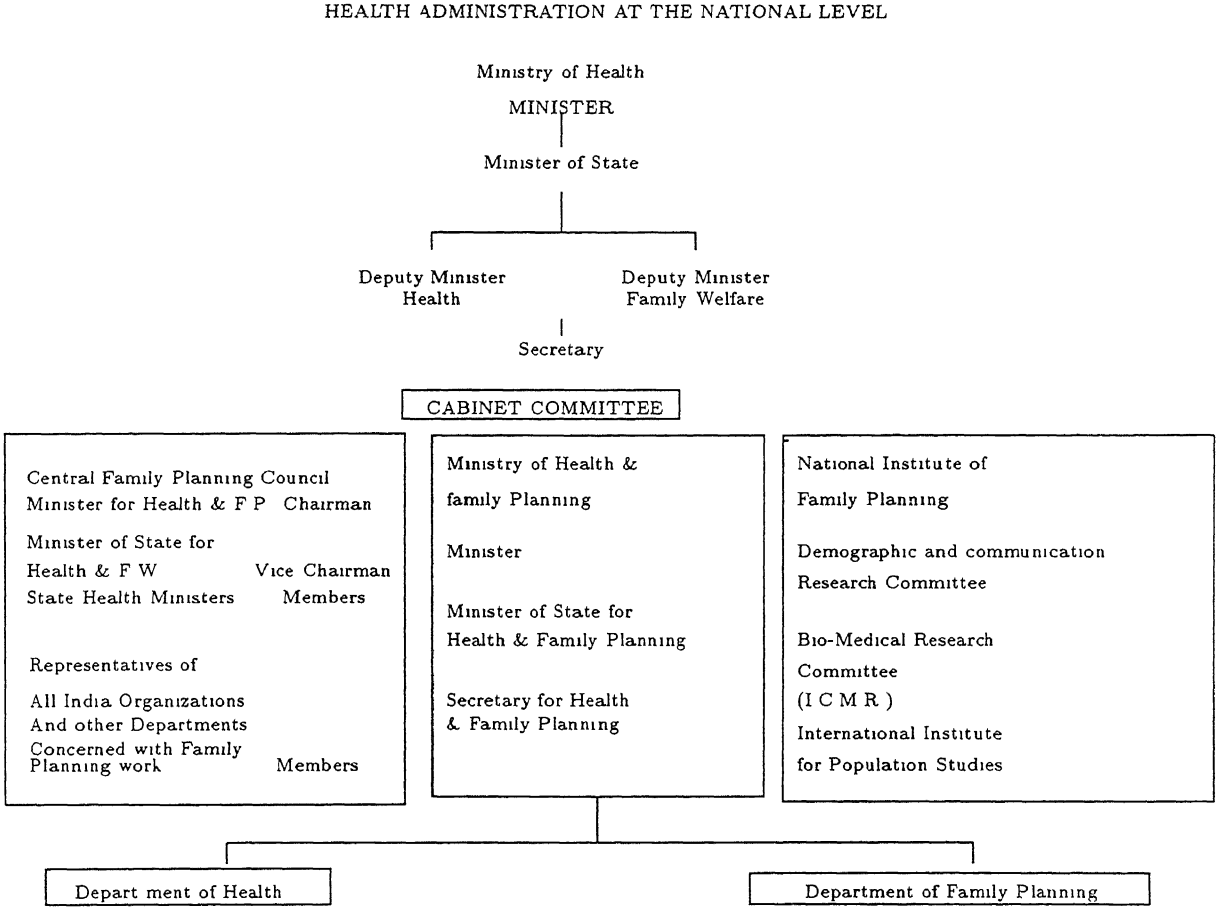


Figure 6 1 Health Administration at the National Level

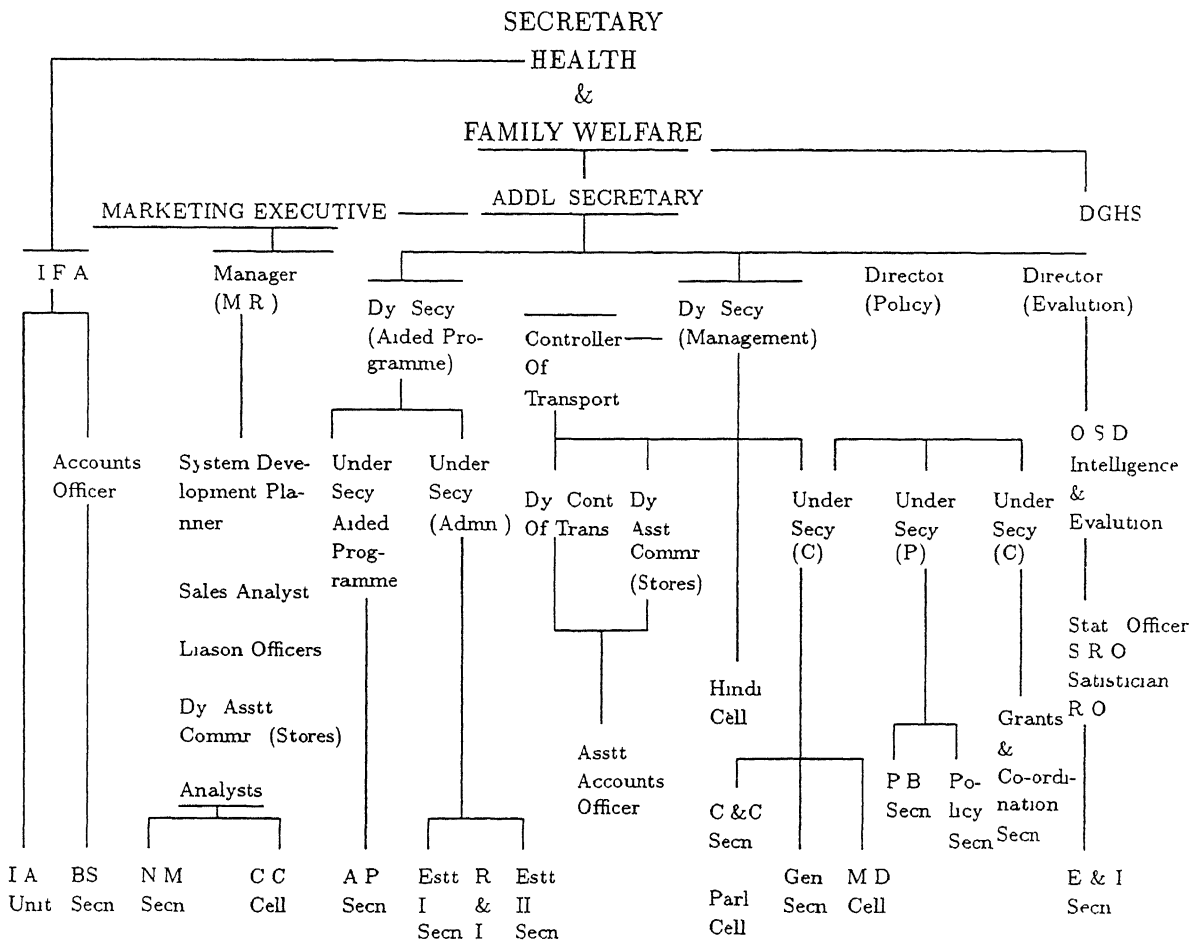


Figure 6 2 Health Administration at the National Level

torate is headed by the Director General of Health Services(DGHS) The Directorate General of Health Services is called as 'attached office' of the Ministry As the Union Government is associated with the maintenance and development of a very wide range of community health activities in the states, even within the circumscribed area of tendering expert advice to the Ministry, the office of the Director General of Health Services has officers who have competence, training and proper skill

The secretariat is responsible for the key functions of policy formulation, planning and recruitment of personnel and financial administration As it represents the views of the Union Government, the Secretariat also deals with its counterpart in the State Governments Various Governmental, and Non-Governmental health Organizations as well as international agencies are affiliated to the Health Ministry

There are two departments in the Ministry of Health and Family Welfare - the Department of Health and Department of Family Welfare Each of these Departments is headed by an additional Secretary, who is assisted by other generalist administrators occupying different positions in the hierarchy- joint secretaries, directors, deputy-secretaries, under- secretaries, and so on

In practice, however, the Ministry of Health and Family Welfare of the Union Government has much more power as the state governments have to depend on it for finances This financial power exerts some control over state governments through various agencies, particularly the National Planning Commission The Union Government is responsible for taking care of international health and international relations This enables the Union Government to make use of the resources made available by various international agencies and government and non-government organizations of foreign countries to ensure the cooperation of states in the health schemes proposed by the international agencies Almost all major health programmer of the country, for example, the various vertical programs, establishment of primary health centers, the family planning program, the multipurpose workers scheme and the community health workers' scheme, were initiated by the Union Ministry of Health and Family Welfare This asserts to its power to influence health services in the states

6.3 Health Administration in Tamil Nadu

Having discussed the national level health bureaucracy, now let us have a look at the state health organization of Tamil Nadu state Tamil Nadu is a state in which the health organization is organized in a very coherent manner The administrative pattern of the state is similar to that of the Union Government(See figure 6 3) A minister of health is responsible to the state cabinet headed by the 'Chief Minister' and the cabinet is collectively responsible to the state legislature Again, the administration is headed by a secretary, who is a non-technical administrator belonging to the Indian Administrative Service(I A S) cadre, assisted by the office of the top ranking health official. The Directorate of Health and Family Welfare Department is called as "Directorate of Medical and Rural Health Services" in Tamil Nadu It has a status of 'attached office' to the state ministry 'The Directorate of Public Health and Continuing Education" is merged with the "Directorate of Public Health and Preventive Medicine" and called as, "The Directorate of Public Health and Preventive Medicine" (G O Ms No 25,HIMFW, dated, 3 1 91)

The above discussion shows that the structure of health services of this state is different from the central health services Firstly, there is no dichotomy between the health and family welfare programmes The services are provided as an integral unit Second, as state governments have considerable executive responsibility for implementing various programmes, the demarcation between 'line' and 'staff' functions is much more clear in the states than the central level

As in the case of the DGHS at a state directorate of health services similar to a DGHS at the center, also has a director who provides leadership to this team with assistance from additional directors and joint directors Deans of the state financed medical colleges and superintendents of large hospitals also report to the director Director of health services also has officers of the rank of deputy directors and assistant directors to assist him/her in fields like malaria, tuberculosis, leprosy, blindness prevention, extended programme on immunization, hospitals and medical care, nursing, health education, health intelligence, drugs control, prevention of food

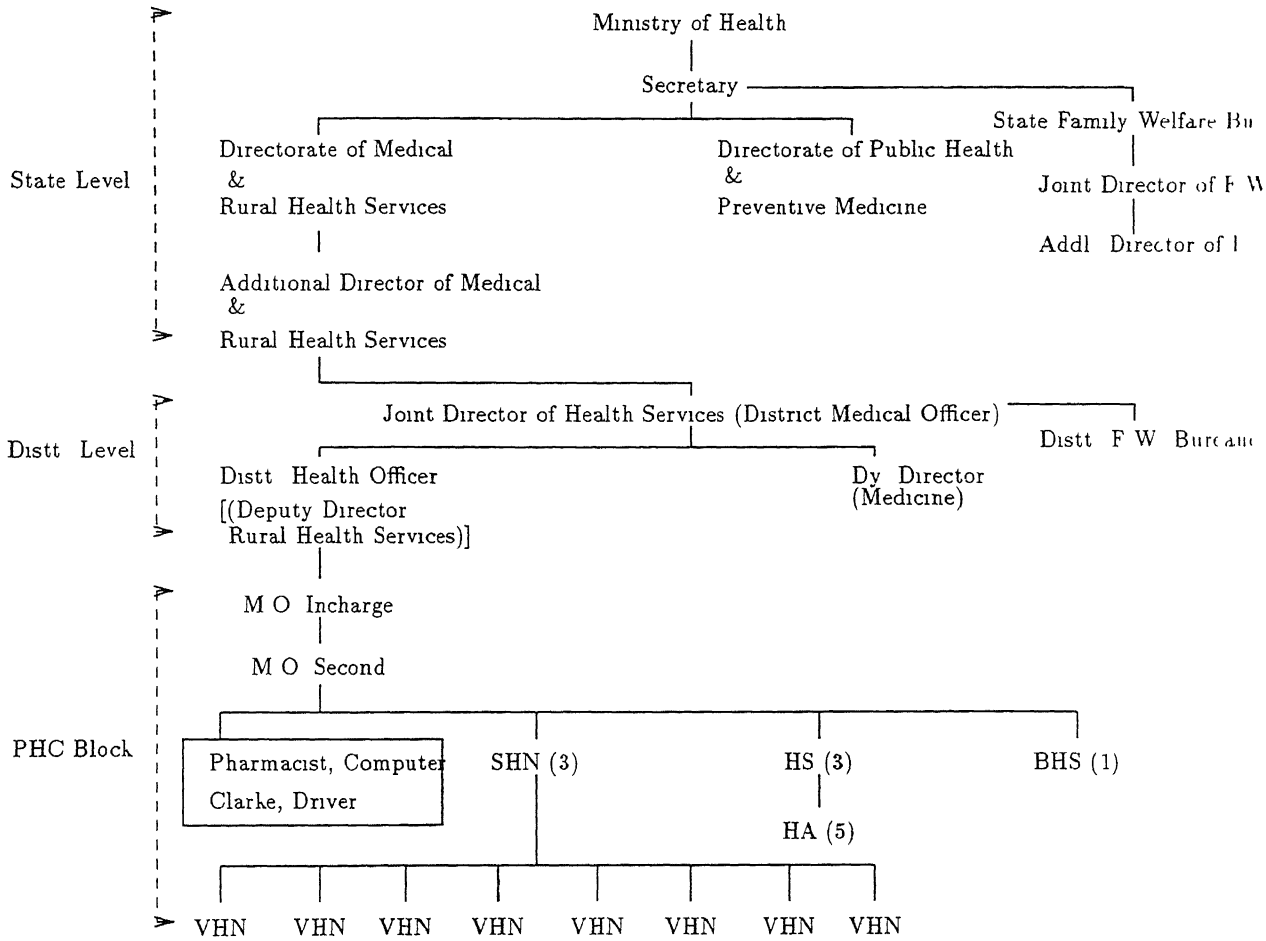


Figure 6 3 Health Administration in Tamil Nadu State

adulteration medical stores, laboratory services and vaccine production and transport A senior officer in the directorate performs the line function of overseeing the work of the district health administration, which runs all the health services in rural areas Health departments of municipalities are responsible for providing preventive and curative health services to urban population

6.4 District Health Administration of Tamil Nadu State

The reorganization of Health and Family Welfare Department took place in Tamil Nadu in 1991 It aimed at integration of the services at all levels The health programmes in the district are placed under one Joint Director of Health Services (refer figure 6 4) He is in the charge of the entire health programmes including public health, family welfare, blindness, tuberculosis, leprosy etc

There are two Deputy Directors at district level One is known as Deputy Director of Medicine, and another is Deputy Director of Rural Health Services The Joint Director of Health Services and the Deputy Director of Health Services are redesigned as District Medical Officer and District Health Officer respectively for statutory purpose The District Family welfare, Maternity and Child Health office is called as "district Family Welfare Bureau" and the Joint Director of Health services shall be the head of office (refer G O Ms No 25, of HIMHFW order dated, 3 1 91)

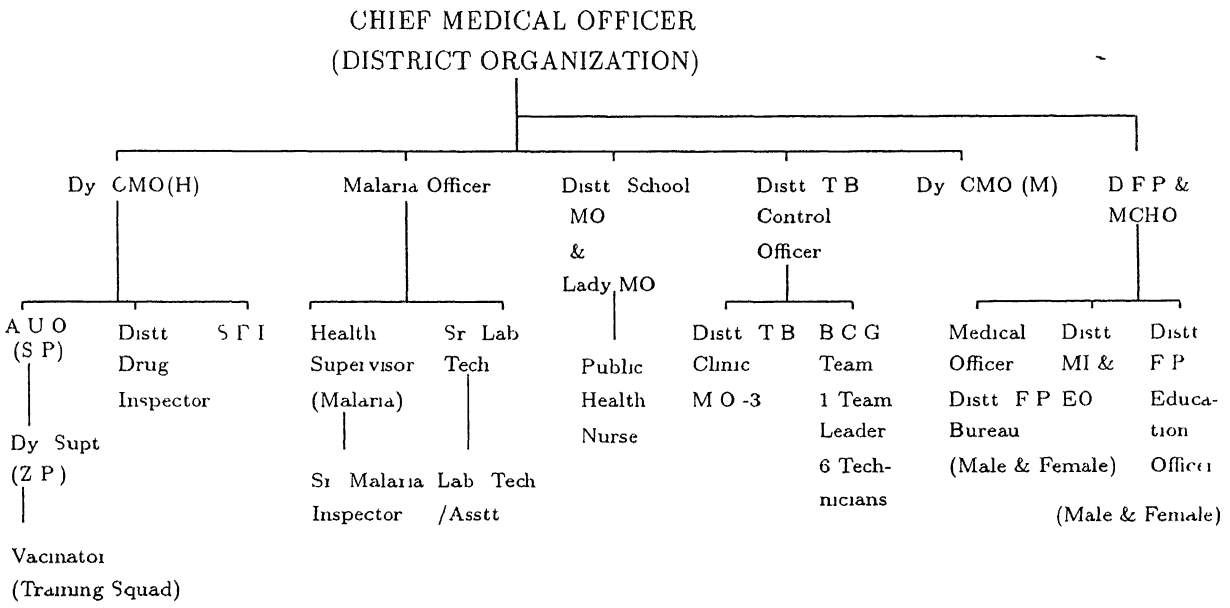
The programmes through which various functions of health units are implemented in the district are -

1 medical care,

2 control of communicable diseases,

3 collection of vital statistics - births & death record,

4 family planning and maternal and child health,



D F P & MCHO District Family Planning & MCH Officer
Dy C M O (H) Deputy Chief Medical Officer (Health)
Dy C M O (M) Deputy Chief Medical Officer (Medical)
A U O (S P) Assistant Unit Officer (Small-pox)
Z P Zilla Parishad
S F I Senior Food Inspector
Distt MI & EO District Mass Information & Education Officer

Note The ministerial staff attached to the CMO's office, Malaria Office and DFP & MCH Office are not shown in this chart

Figure 6 4 Health Administration at the District Level

5 environmental sanitation (including prevention of food adulteration) and

6 school health

The entire population of district is covered by 12 primary health centers (P H C) and they get line and staff support from the office of the CMO Besides the PHCs, the office of the CMO also supervises the work of a number of dispensaries, of allopathic (about 30-40) and indigenous systems (about 8-12) This organisational set-up brings as to block hospitals

6.5 Block Setup of Tamil Nadu

The health programmes of the block are undertaken by two Primary Health Centers(P H C) P H Cs are manned by two doctors, one doctor is made incharge of the P H C and he is supposed to supervise the entire health programmes of the operational area of the block While another doctor is supposed to work under the Incharge of the hospsital as second in command It means in the absence of the medical incharge, the second doctor would look after the duties of the medical incharge (see figure 6 5) There is a Medical incharge who is incharge of the entire health programmes in the operational area There is a Medical Officer second under Medical Officer incharge

At the primary health center level, line functions are predominant The medical officer incharge provides leadership to other physicians, nurses, laboratory scientists, block extension educators, health assistants and multipurpose workers He works along with the community population covered under his PHC In addition to this he is supposed to act as a ctalyst for bringing change in the orientation of population

The above description suggests that administration and organization of health services in Tamil Nadu is divided into 3 tiered structure, state, district and blocks

Health services are designed to reach out to virtually each of the over 56 million household, located in over 560,000 villages, towns and cities of the country This task presents a major challenge to health administrators of the country Increase in

ORGANIZATIONAL CHART OF THE PRIMARY HEALTH CENTRE AT BLOCK LEVEL

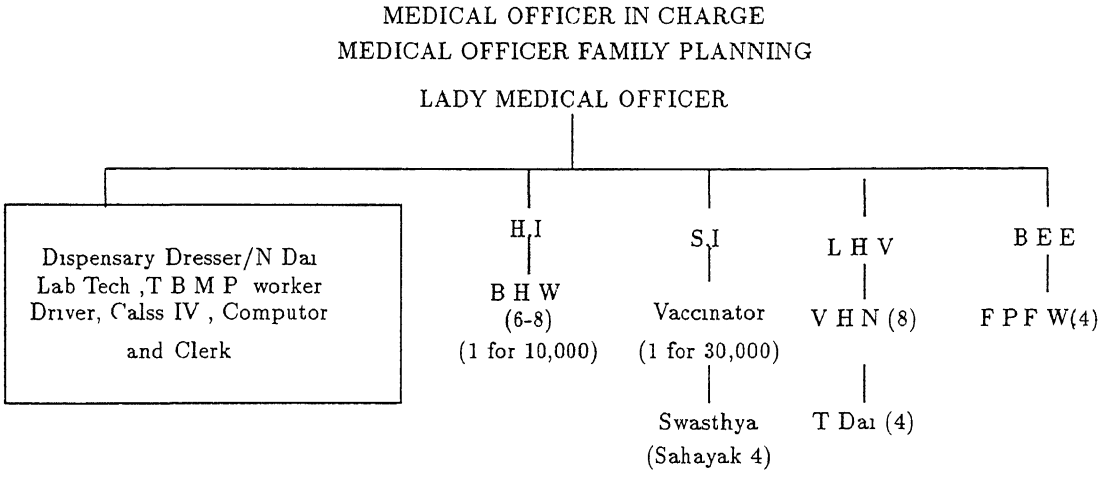


Figure 6 5 Organizational set-up at the Block Level

the domination of generalist administrators and failure to introduce a proper medical cadre of pan Indian nature have generated the lack of managerial orientation in the contemporary health-administration of India The virtual absence of managerial physicians who can properly shoulder the new types of responsibilities have become the major obstacles that has affected the proper functioning of delivery system of health care

Now let us have a look at the delivery system of health care units Generally the term 'delivery' means conveying or distributing goods and services to a destination For health delivery we mean hospitals and dispanceries which come into direct contact of population and they are supposed to render the services of health care to the masses

6.6 Health Care Delivery System

Health care delivery system is a system in which the services related to health are delivered to the target population In Health care only planning is done by the higher level officials while implementation is normally looked after by the local staff In India including Tamil Nadu, the implementing agency of health care programmes is at block level known as Primary Health Centers (P H C) The structure of P H Cs are already mentioned in the first section of the Chapter (see figure 6 5 for reference) The Medical officer in charge of the P H C , is assisted by another Medical Officer in looking after the activities of P H Cs There is a Block health supervisor who supervises the health activities of the block Hospitals Under him there happens to be a computer to compute various data, a pharmacist to provide medicines, a Block Extension Educator for propagation of health education through various orientation training camps Generally these camps are focussed on Information dessimination, health education etc In addition to this under the Block health supervisor there are three Health Supervisors and five Health Assistants and three Sector Health Nurses The supervisors and health assistants visit the villages for pathological aids, while the sector health nurses are sent to villages to monitor the activities of Village Health Nurses(V H N) The Village Health Nurses are the lower level staffs who are engaged

in the village health units There are eight health sub centers attached to one P H C Each Health Sub Center has one V H Ns The duties of the V H Ns are of Pre Natal Care, Post Natal Care, immunization, taking care of sick population by making daily rounds of their villages They have to stay within the Health Sub Centers for all the 24 hours V H Ns are the key functionaries of Health Sub Centres and they have to provide medical help round the clock These V H Ns are assisted by 5 trained mid-wives(dais) in each sub - parts (hamlets) of each village These sub - parts are made only for the health operational purposes There are also 5 trained dais in each hamlet in an operational area of a Health Sub Center

Since important roles are played by the block and village health officials (Medical Officers, Village Health Nurses, Sector Health Nurses, etc), it was thought to collect some detailed information on delivery processes from the different levels of health officials and the village respondents This section is devoted to present the detailed accounts on nature of work, constraints of implementing agencies and respondents opinion on functioning of health burcaurancy of village India

6.7 Hierarchical Structure

It is observed that the organizational set-up of health care organization is hierachical and it is comprising of a centralized system The delegation of power is not very effective and clear In the health care delivery organizations, the specializations include, immunization, inoculation, epidemic control, etc , and the officials are given various the assignments to take care of the segmental issues Each individual pursues his own task without bothering about the total segment of tasks as a whole, as if it was the subject of a sub contract Consequently, each officer feels that, 'Somebody at the top' is responsible for seeing the entire organizational task decision making process The subordinates are not having power to take any decisions regarding plans and programs Hence, the subordinates always look towards their bosses for some clear cut orders directions and planning as reported by the Health Officer of P H Cs This suggests that the delivery system is mechanistic and vertical(Burns and Stalker,1961)in

nature In a mechanistic kind of organization the tasks are broken down into various specializations as is the case of P H Cs of Villages A and B This finding further suggests that the organizational structure of village hospitals is not only mechanistic but rigid too As we have already discussed elsewhere that the technical methods, duties, and powers attached to each level are precisely written down and are accordingly informed to individual officers of each level for following upon

There are both merits and demerits of the mechanistic model For example, in case of the projects related to immunization, family planning etc , this kind of rigidity is needed in work-allocation Therefore, for such programs this system is a boon Because of this, Tamil Nadu could achieve 100 percent immunization and could reach to top ranking position But in case of individual treatment which varies from location to location, person to person one requires to have certain kind of flexibility so that personal attention and personalized care can be given This cannot be tackled with rigid directions Therefore, one requires to have a

balance between rigidity and flexibility of decisions There is lack of this kind of balance in the village health organization of the sample population

1 *Lack of delegation of power* The health officials informed that for each and every issue of P H Cs the decisions are taken in the state health directorate In those decisions, P H C's members (block and village level) are hardly involved in Consequently, there is complete lack of correspondence between the diecisions taken and the action desired to be taken This leads to either wiong decisions or delayed actions The Medical Officers of the Kodaikanal and Nilokkottai Blocks and the Village Health Nurses of the Michael Palayam and Periyur Health Sub Centers informed that the centralized power of direction and guidance often leads to inordinate delays They mentioned that, were area specific (geographical) have to be tackled by the local official who were conversant with the problems But gener- ally it was not done and the district level authorities who didn't have proper understanding of the local problems were asked to decide This invariably leads to serious consequences like death or out break of an epidemic They informed that village A has different kind of

climatic condition The residents of vil- lage A suffer from sickness like Asthma and other cold related sicknesses which was linked with the climatic condition of this village only No special programme or fund allocation was made to the village A's P H C to keep the disease in control Consequently, large number of residents were suffering from the disease and the village health officials are the spectators They further suggested that this disease was being ignored because the district level health authorities were not able to comprehend the problem According to them solution of this lied in the hands of local administration provided the power was transferred to them

2 *Lack of proper resource allocation based on the individual requirements of villages and P H Cs* The health programmes applicable to local populations are made and imposed by the state health administration The state health administration lacking real contact with the implementing agencies Due to lack of intercommunication between the state and decentralized institutions, there exists a gap in allocation of resources In the present exercise, it was thought to contact some block level officials who might be helpful in providing with the problems at field level The Medical Officer informed us that the Primary Health Centers(P H C) were not able to pay proper attention on health problems of villagers because of the lack of funds Further, the medical officer informed us that presently the village needed more medicine to take care of gastro-entities, jaundice etc , but they were unable to purchase them since they did not have any fund with them at their disposal Consequently, the villag ers had to face difficulties at the time of crisis

3 *Lack of equitable distribution of duties and responsibilities* It was observed that in health administra tion, the duties and responsibilities of different health offi cials of different levels generally were decided by the state authority They distribute the job based on the inputs avail able in the district officers The Medical Officers of the P H Cs and the Village Health Nurses of both the villages mentioned that there were unequal distribution of duties and responsibilities The

nurses reported that they were given responsibilities of maintaining the records of births and deaths, immunization, etc , in addition to taking care of patients On the other hand, the other health staffs, such as, Health Assistants, Health Supervisors and Health Inspectors were given very few responsibilities They were generally involved in the supervision of different activities Consequently, the nurses invariably were making complains against the administration for not distributing the responsibilities in an equitable manner This suggested that the female health staff had more and diverse responsibilities to carry on, while the male staff had less duties Due to the unequal distribution of duties, it was observed that the Village Health Nurses and Sector Health Nurses of sample villages were losing interests in their jobs and were having a feeling of injustice It is interesting to suggest that this was not a lone case but it was a norm of almost all P H Cs

In the above paragraphs the structure and function of government Health care organization is discussed However, there are some Non Governmental Organizations engaged in health and family welfare activities in the sample village of our study Therefore, it was decided to collect some information on structure and functions of such organizations Collected information are presented in the following paragraphs

6.8 The structure and functions of Non Governmental Organizations:

The operation of N G O s was found very different from the governmental health units Findings suggest that they have lateral relationship between superiors and subordinates This kind of relationship may be termed as organic organizations

The organic or organismic structures are flexible in nature (Morgan,Gareth,1988) Organic structures, are adapted to unstable conditions, when problems and requirements for action arise which cannot be broken down and distributed among specialist

Table 6 1 Patteins Of Organization And Management In Governmental And Non Goveinmental Health Organizations

	GOVERNMENTAL HEALTH ORGANIZATIONS	NON GOVERNMENTAL/ HEALTH ORGANIZATIONS
Nature of organization	Relatively stable	Flexible(time to time variation)
Nature of task	Achievement of fixed targets efficiently	Need based
Organization of work	Clearly defined jobs arranged in hierarchical pattern	Jobs defined by individuals concerned through interaction with others
Nature of authority	Clearly defined and vested in formal position of hierarchy, seniority important	Pattern of authority informal and constantly changing as roles become redefined with changing circumstances vested in appropriate skills and abilities
Nature of Communication system	Vertical	Completely free
Nature of Employee commitment	Commitment to own particular jobs	Commitment to central task

roles within a clearly defined hierarchy Sickness is a situation which cannot be predicted in a specific point of time It is because of unstable conditions It varies from person to person, region to region and culture to culture Because of this, the N G Os follow flexible organic approach to solve such problems Individuals perform their tasks based on their own skill and training Jobs lose much of their formal definition in terms of methods, duties and powers, which have to be redefined continuously by interaction with others Interaction runs laterally as much as vertically, communication between people of different ranks tends to resemble lateral consultation rather than vertical command The Nurse (N G Os) who stayed in the village attended the cases with her own technical skills with out depending on the orders of the superior body

6.9 Conclusion:

Presuming that the nature of hierarchy plays an important part in health bureaucracy the respondents were asked about difficulties arising out of hierarchy in health delivery - processes From the information made available by the respondents it was revealed that centralised control created problem in dealing with emergency situation Consequently, respondents did not prefer to go to government hospital if it was a matter of life and death They felt that by the time help would arrive to them, something unwarranted would happen To some extent the respondents views were also supported by the statements of health officials of the P H Cs

6.9.1 Procedural devices:

Different level of offices have different functional responsibilities but they are supposed to act in coordination Therefore, coordination becomes the basic ingredient of an efficient bureaucracy The possibility of reaching to this objective largely depends upon procedural devices Procedural devices involve information in proper form from the right kind of personnel and speedy action taken on the content of information with proper consultation Normally, it is presumed that the role of the field informations

would be very crucial and their information or noting should be the most important device However, respondents and the village health functionaries informed that things did not happen in this form The lower officials were the first to record the facts of the case and subsequent actions to be taken on a file As the files move upward in the hierarchy, the higher officers are free to accept their opinions or take decisions over riding them More often the higher officials decided and the issue also giving the comments/opinions of the field medical officers However the field officers (health) reported that sometimes they did require to consult their bosses because of certain doubts about some rules or some clarification sought on certain orders

To probe further on the issue of decision - making process we asked some questions to health officers and the respondents Answers presented some fascinating aspects of the decision making process in bureaucratic functioning The village health officials mentioned that many decisions related to policy issues, instruments to meet the policy requirements fund distribution etc , were dependent upon the nature of cases In general it was observed that the superior officers had the deciding power on each and every issue The sense of powerlessness and consequent lack of a sense of responsibility found among the junior health officers apparently affected the overall functioning of the public health - care units and their delivery units as per the opinions of the respondents

Chapter 7

Conclusion

To promote the awareness towards healthcare, number of conventions were held by international organisations such as World Health Organisation (W H O), UNICEF, etc One among them was the "Alma Ata" convention by W H O held in 1978 The main resolution adopted in this convention was to achieve " Health for all by 2000 A D " Now the goal of each and every nation is to achieve the above task In achieving the above task, what are the processes (directly and indirectly) involed in ? Where to pay greater attention ? What are the channels through which one can try to achieve the best health? etc The present endeavour is an attempt to answer the above questions India is a country with majority of population living in rural areas Hence, the present study is undertaken to understand the health behaviour of rural masses This study attempted to firstly examine the applicability of the concept of "Sick Role Theory" with the rural population of Tamil Nadu Second , it introduces the concept of health-system to assess the importance of network in rural population Thus, the overall thrust of the study is to understand the dynamics of health-culture of rural population of Tamil Nadu in frame reference of 'sick role theory' and health as a composite system However, a few more objectives were kept in mind and they are given

1 to find out the interlinkages among the various units of health care,

2 to examine the impact of cultural orientation such as customs, rituals and di-

etary practices on health,

3 to understand the process of health care decisions made by individuals of the rural community of Tamil Nadu,

4 to familiarise with the administrative setup of rural health care units and their delivery system functioning in rural Tamil Nadu,

5 to comprehend the nature of relationship among the various levels of functionaries of health administration as well as the rural population,

6 to suggest some tentative theoretical formulation for the health dynamics of rural India,

7 to suggest some steps for improvement in health care network with specific reference to rural population

Keeping the above objectives in mind ten major hypotheses were formulated for empirical verification

7.1 Hypotheses

1 Stronger the community bond, better is the health

2 Higher is the Socio Economic Status, better is the health care choices

3 Better is family care, less is the incidence of sickness

4 Greater is the health discipline, less is incidence of sickness

5 Preventive measures of more acceptable than the modern medicare

6 Cultural tradition influences the health care decisions

7 Greater is the formalisation of health bureaucracy better is the delivery system

Health is a social issue and therefore it is important for all of us to take care of our health so that we become a citizen of healthy nation In India, health does not have importance like industry and other sectors with respect to fund allocation in our budgets To prove this let us have a look at the allocation on health

Table 7 1 Per Capita Expenditure on health (Medical and Public Health)

Per Capita Expenditure on Health		
	India	Tamil Nadu
1975-76	11 82	12 17
1976-77	13 31	15 63
1977-78	15 05	14 73
1980-81	23 53	20 99
1981-82	27 86	30 10
1982-83	32 85	37 18

Source Handbook on Social Welfare Statistics, (1981) Ministry of Social Welfare, Government of India, New Delhi

For example, in 1981, there were 8,626 hospitals with 540,768 beds or 1 bed per 1,265 inhabitants in India Further there were only 268,712 physicians, or 1 per 2,545 inhabitants, 8,548 dentists and 150,339 nursing personal for treating the patients in India Likewise, in Tamil Nadu, the ratio is 1 physician per 3408 persons and 1 dentist per 1,24845 persons

The percapita expenditure on health statistics shows that not even one percent of percapita income has been spent on health Thus, health is given lowest priority in National budgets and plans The above figures show as to how health is ignored Therefore the time has come that researches must play some attention on this aspects so that Alma Ata resolution can be achieved

Health as a system

In this study we have assumed that health of individuals comes into peripheral domain of three interdependent sub systems They are man, community, and health

organisation (See Chapter 3) Each sub system is comparising of many elements All the elements in the units of man, community and health care are interacting with each other However, all elements do not have equal importance at all point of time For example, it was observed in the unit of man that income is more important than age Likewise the variables such as caste, occupation are more influential than any other variable Further, it is very interesting to note that education has shown inverse relationship with good health contrary to the general assumptions that educated persons would be more aware of health issues and therefore they would keep better health than the uneducated ones

Similarly, in the unit of community, the affliation, social division , and ritualism are important The sub elements of ritualsim such as fasting, diet restriction, worshiping have positive relationship, with health The ritualism is disciplined way of living It is a routine of activities which is helpful to keep oneself fit at all levels Ritualism is a rational act, which includes preventive measures of health such as ritual acts linked with exercise, Yoga, Meditation, herbal meditation etc

Further, similar relationship was observed in health organisation The elements of health organisation, the organisational set up, resources, personnel, and awareness campaign are shown equal importance In health organisation, these are two types of organisations One type of organisation is Governmental Health Organisation and another type is Non Governmental, Voluntary Organisations In the Governmental Health Organisation the Organisation's structure is very strong and rich in resources and personnel when compared with Non Governmental Health Organisation Even-though the Government Health Organisations are rich in resources and personal and functioning in a structure, the health delivery is poor The Non Governmental Organisations are having better delivery system than Governmental units It is due to the commitment and involvement in the service It is also due to poor awareness compaign

Health is a total system comprising of major sub units Man, Community and Health care organisation and sub elements of each sub unit Health is dependent on all these elements Health is outcome of interaction between all these elements Hence,

Health is a total system In the unit of health organisation, the Non-Governmental and traditional unorganised health sector is more influential than the governmental organisation It is due to the poor delivery system and very few cases awareness programmes by the governmental health sector It is also as a result of ignoring the indegenous medicines by the public authority

Dietary Practices Linked with Health:

There are difference in food habits among different community It is generally thought that vegetarian diet are good for health However, contrary to this it observed in this study that non - vegetarian meals which provide better intake of nutrition help in keeping good health more than the vegetarian diet people can get more nutritional valued food than the belonging to high caste categories The Medical Officer of the additional Primary Health Centre mentioned that there were more cases of aneamia found among the higher caste people of the village than the lower caste Therefore, the medical officers conclusion was that there was a link between the vegetarian meals and the incidences of anemic cases

Traditionality verses Modernity:

It is very interesting to note that most of the respondents of the study were very traditional or religious-minded Out of high health status category there are 54 7 percent of highly religious and 45 2 percent of high healthy persons are moderately religious, while no one in the high healthy persons are less religious On the other hand among the less healthy persons, 57 6 percent of less healthy persons are moderately religious and 42 3 percent of less healthy persons areless religious(see table 5 5) The above findings suggests that they have less incidences of sickness than the modern families who do not follow strict religious code of conduct For example, rituals are helpful to keep one healthy The rituals include hygienic habits such as taking bath early morning, washing face and hands before taking meals etc , not using the chappals etc inside the house which keeps the home environment very clean abstaining from intoxicants like cigars etc help maintaining good health Likewise, periodical fasting is another religious act which is very helpful in keeping good health

Unaffordability of modernised medicine:

Further it was observed that allopathic treatment was considered to be a very expensive kind of treatment as reported by the respondents Therefore more often the destitude respondents approached quarks, homeopaths, and other kind of practices They feel the traditional medicine is more effective than the modern medicine Only common diseases could be treated from the Health Sub Centres and Primary Health Centres In village A, a voluntary health unit was functioning for the tribal population for mild health problems and carry them to Christian Fellowship Hospital- of their organisation incase of emergency

Curative health Vs preventive health

With relation to community we find divergent health practices among the tribal and non-tribal communities For example, tribal people use herbal medicines for common diseases The tribal respondents reported that they often go to the 'pachilai vaidiyam'(quacks) locally for herbal medicines The pachilai vaidiyams collect herbs from the nearby hills Respondents did mention that herbal medicines work faster than the allopathic medicines To prove their points they informed us many incidents such as once a respondent had fractured his leg, he first visited the P H C for treatment He took medicines for many months but he could not get cured Atleast two friends advised him to see a quack he underwent herbal treatment given by a 'Pachilai vaidiyam' for two months And he was completely cured It was further observed that some of the folk treatments were more effective and reliable than the allopathic medicine Consequently folk medicine and visit to quacks were more common among the respondents However, this finding is contrary to the findings of Kamble(1984) Kamble study reported patients, regardless of their occupations took treatment from doctors instead of vaidyas and self treatment Not even a single patient from among cultivators and agricultural labourers took treatment from vaidyas (Kamble, 1984) While present study shows that respondents preferred herbal and Ayurvedic medicines more than the allopathic treatment Especially, the cultivators and agricultural labourers prefer traditional treatment

Social division adversly affects the health of lower caste

Caste groups were studied in the context of its relevance as factors influencing

health behaviour It is strange to observe that the social division is having an adverse impact on the health of lower caste individuals For example, lower caste persons are not allowed to wear foot wear in the high caste settlement zones Since, the main road and other infrastructural facilities are available near the higher caste settlements the people of lower caste have to cross the higher caste zone Open sanitation is common in the village on the road Due to this, there are communicable diseases common among the lower caste population The findings of the present study confirms the findings of Banerji(1982) The Banerji's study's findings show that the health culture is influenced by the discrimination of lower castes by higher castes

Education is adversely affecting health

Education is adversely affecting the health of individuals (see chapter 4) In the present study it is shown that among the respondents, people who are educated more are not strict in following preventive measures, they are not strict in following exemptions, they are not following diet control properly , and not strict in following personal hygienic habits

Rural occupations affect the health of individuals:

Like other occupations, even in the agriculture and related activities there are different occupational hazards Among the tribal population, there is a habit of climbing very thin trees to collect a kind of green algae The algae is sold to pharmaceutical unit for Rupees Thirty per Kilo gram While the researcher was in the field, he also witnessed a death of a person who fell down from a tree while collecting the algae There are also similar cases in other activities such as well digging, wood sawing etc In case of agriculture there are cases of skin diseases and breathing problems among the agricultural labourers while using the fertilizers and pesticides Some of the poisonous Pesticides also lead to serious health problems in the village

Ineffective Health Bureaucracy is the main cause for poor health delivery system in the Public Health system

The health bureaucracy is the main cause for poor health care delivery system The public health care units are rigid in nature Because of that they are unable

to discharge better service to the needy population The major reasons for the poor delivery are the following

1 Planning is done in the higher level, and grassroot level workers are not involved in it while the delivery units are functioning at the local level Grassroot level Health workers come into direct contact of patients at the local level and they have all kinds of information on local needs Since the local health workers are not involved in health - planning therefore, the plans and programmes become ineffective Further, the lower level implementing agencies are expected to take permission from the higher level in all cases of need Due to this, the health services at village level suffer a lot

Moreover the P H Cs informed us that there was acute shortage of fund consequently, the P H C s, were not able to buy essential items

2 There is a lack of fund allocation for health sector

3 There is a lack of proper distribution of responsibilities There is an unbalanced distribution of responsibilities among the different health staffs Which affects the interests of the delivery staffs For example, the Health Assistants and Health Supervisors all having less responsibilities than the Village Health Nurses and Sector Health Nurses

7.2 Suggestions

1 *Health sector should be given higher priority* As health is an important sector more allocation of money should be made The percapita expenditure on health should be increased Like other sectors health sector also should be given equal priority in the budget of the State and Central Governments More and more Primary Health Centres and Health Sub Centres should be opened

2 *The indigenous medicines should be recognised*

The indigenous health practices should be recognised and encouraged to develop for the further population It is a kind of medicine which is favoured by most of the village population The indigenous medicines are cheaper and easily accessible to rural population There are people who practice in the traditional medicine in the villages hence there is no need to go for any kind of training but should be recognised By recognising the indigenous medicines it will be helpful for the villagers with the cheaper choice and for the practitioners with an employment opportunity

3 *The traditional practices helpful to keep one healthy should be encouraged*

There are some traditional practices which are helpful to keep one healthy such as, taking bath in the mornings, keeping home and environment clean, personal hygienic habits should be encouraged For example, the villagers are having a habit of cleaning the home environment with cowdung Which is keeping the mud floor like a concrete floor and as well as it is very helpful to keep the inhabitants from the microorganisms It also observed people who are fasting regularly are having better diet control than others The actions which are good for the health and keeping the environment clean should be encouraged and rational decisions should be taken on such actions which lead to wrong beliefs

4 Parsons' "Sick Role Theory" may be replaced by health system approach For rural population of Tamil Nadu, sickness is not considered to be individuals' responsibility They considered it as a social responsibility and therefore in the event of sickness all the kin group members as well as well wishers tried to put in efforts for the cure of the sick persons However, sick persons could not avail the exemptions from performing their economic roles because of the family needs But the family members gave all the other kinds of help, such as taking the sick-persons to the physicians providing the sick persons with emotional, physical and material help

5 *The preventive measures should be given priority*

In health sector the main focus is on Protective measures But the main focus should be changed to preventive and promotive measures

6 *There should be delegation of power and authority to the lower level health units*

The health units functioning in the lower level are not given any power to take any decision on their activities But those are the implementing agencies But the planning is done in the higher level which is no way connected with implementation There is need for delegation of power and authority to lower health units, while presently there is only delegation of responsibilities

7 *Promotion and Preservation of Indigenous Drugs Available in Food Items*

Unlike the urban societies with the boon of modern science who shaped the physical and biological environment to their taste, the rural communities of Tamil Nadu depended more on their environment for their cultural, material and other needs until recently

The forests and the natural surroundings provided them an intimate association with the varied kind vegetable plants flowers etc Through the experience of generations villages have learnt the optimum utilisation of the plants and flora and fauna existing around them Several thousand plants of the environment of this area need be preserved and explored for their medicinal, nutritional, fibre content and other economic value Before the plants, herbs etc disappear because of the rapid process of urbanisation it is essential that one should promote and pressure them

8 *Indigenous Item Food as Sources of Drugs*

(a) *Raw Plants/parts/product* No physical treatment is carried out

(a) Latex Eupherbia nerifolia, locally in Guinea-worm disease

(b) Seeds Heteropagon contortus, orally in retention of urine and intestinal obstructions

(b) *Juice/simple rubbing of plant part*

(a) Tridax procumbens plant juice as a blood coagulant

(b) Butea monosperma stem bar krubbed as antidote to itching caused by contract with Mucuna pruriens fruits

(c) *Plant part taken in an edible form* Many times the drug is taken with good by either powdering, burning or frying it and mixing with other ingredients

(a) In cough and colds, baked Zingiber officinale are pounded separately and is eaten

(d) *Extracts* Prepared by crushing fresh drug in water or slicing the plant material in water with/without straining

(a) Abelmosclus moschatus roots in abdominal pains orally (extract or crushed drug used)

(b) Balanites aegyptiaca root taken as extract orally to relieve dysentery

(c) Asparagus racemosus stem extract by slicing in water to relieve chronic dysentery

(e) *Ash of plants*

(a) Achyranthes arpera var, porphyristachy is burnt, the ash with maize flour doubgh baked into 'pania" sandwiched between two Butea monosperma leaves, for coughs and colds

(b) for coughs and colds the ash of mature Calotropis procera leaves kept on tongue

(f) *Pastes*

Drugs are simply made into passe and applied locally on the ailing region of human body Passe of Terminalia thebula applied in abdominal pains Administration of drugs in paste form either locally or orally is the most frequent mode The liquid medium used may be water or oil

(a) Azadirachta indica paste used in boiles

(b) Balanites aegyptiaca root paste locally applied in internal haemorrhages resulting from accidental falls

(c) Opium paste applied on irritating sport of Guinea - worm which either dies or is expelled

(g) *Decoctions*

(a) Solanum Trilobatum root decoction given in caugh

(b) Piper nigrum seed is given as decoction in fevers to bring down temperature

(c) In tonsilities in children the paste of Zingiber officinale is rubbed on tongue

(d) Diespyres melanoxylon stem bark paste prepared in oil is applied as ointment on myatic wounds

(h) *As toothbrush*

Besides using them for diseases of teeth, twigs/plant parts are used for other purposes too Toothache is treated by brushing teeth with Azadirachta Indica seems

(i) *Vapour baths*

As evidenced by their frequent use, a fair knowledge of plants and curative technique by this method is observed

(a) Burning, Tectona grandis leaves are burnt and the fumes inhaled in Guniea worm disease The swelling of wound reduces

(b) Boiling The steam bark of any one of Pterocarpus marsupium var, acuminatus, Bakuhinia racemosa and Bridelia ratusa is boiled and vapour bath given for restorative action to a mother after childbirth

(c) Anisemeles indica whole plant or at times only the stem to cure facial swellings by inhaling vapours

(j) *Complex treatments involving one or more plants*

In Anaemia Pterocarpus marsupium var, acuminatus stem bark is given as decoction before sunrise Regulated diet is kept for one week necessarily in which a uniform meal of any grain is eaten and spices avoided

(k) Preservation and promotion of indegenous medical aids Western model of health care services would not be able to deliver the goods because of their overemphasis on curative approach Moreover, it is well known that Indian villages have already indigenous medicine practitioners and homeopaths in abundance It is reported that there are more than four lakhs of indigenous medicine practitioner in India and most of them are living in villages of India(Mehta, 99 1992) Why this rich source of medical care may be left unutilised ? The indegenous medicine practitioners belong to the local world and have developed an identity with the village folks In addition there is sharing of values and norms with the villagers Therefore, an indigenous medicine practitioner is better accepted and are easily accessible to the villagers than a P H C doctor Thus, it can be suggested that instead of increasing the number of medical colleges the the government and health planners should pay attention to augment the resources of indegenous medicine practioners to the target set by the Alma Ata Declaration

7.3 Concluding Remarks:

Though having evolved away from the modern civilisation, the rural system of medicine is an elaborate and specialised one A preference for fresh drugs is seen While some of the drugs are exclusive treasures of specialists often exclusively administered by them, the other members of the community are also aware of the therapeutic properties of plants from their day to day experience Most of the drugs are freely available If not, there are substitutes find in the surrounding areas Most of them are efficacious, if not, there are often more potent forms The remote villages still depended on the forest herbal resources for their survival The rate of acculturisation, however, is fast and so is the rate of degradation of their health ecosystems

It is necessary that the rural knowledge and practice about food items having medicinal value are to be recorded before they are lost permanently Before the villagers adopt and accept the modern medicine completely their own herbal materia medicine is to be documented as many of the drugs used have potential of being incorporated, after proper screening and experimentation in modern medicine

All this needs an early probe in an organised and systematised manner by several organisations such as surveys and welfare societies, research institutions to work in a coordinated manner unlike the present trend of studies which are mostly either restricted towards making inventories or are scattered A very interesting observation found in the study by the present author was that some of the herbal medicines and their uses were akin to those used in Ayruveda Therefore it is suggested that the rural herbal medicine must be promoted in order to achieve the goal of 'Health for all by 2000 AD "

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Appendix A

NATURE AND DYNAMICS OF HELATH CULTURE A CASE OF RURAL POPULATION OF TAMILNADU

Religious practices

1 What are all religious communities in your village?

Hindu/Muslim/Christian/Any other

2 How freuently you go to place of worship(temple/church/mosque/anyother)?

Daily/once in a week/once in a month/occasionally

3 How often do you meet other community members?

Very often/occasionally/not at all

4 What are the celebrations you have in your family?

5 Who are your deities/gods?

6 Do you offer any offerings to god?

Yes/No

If yes what do you offer?

How often?

When?

7 What the funtion is called?

8 Did your offering solve your problems?

Yes/No

If yes to whom?

9 Do you believe in religious rituals for common cure?

Yes/No

10 Do you observe any fast at home?

Yes/No

If yes, how often?

If no, what do you do?

Food and Nutrition

11 Do you observe any restriction on your diet?

Yes/No

If yes, of what kind?

12 What are the common food items of your daily meals?

Rice/vegetables/dhal/milk and milk products/eggs/meat/mutton/chicken/beaf/pork/sweets/green vegetables/leafy vegetables/any other

13 Do you consume any sprouted grains(eg gram,whole moong)?

Yes/No

Facilities

Facilities	Types
Health	Hospital/Medical centre/resiential Doctor/Trained nurses/ Dhais/anyother
Electricity	House/Farming/Street lights/irrigation
Transportation	Bus/Train/Bullock carts/cycle/any other
Market	Public Market/private/intermediaries/agents/ Co-operative m
Telecommunication	Post office/telegraphic centre/other telecom centres
Bank	Public sector/nationalised/lead bank/private/cooperative/ money lenders
Library	Public/permenant/mobile/full time/part time/private/ circulation library/any other
Veterinary Hospital	Veterinary hospital/subcentre/artifical insemination centre/ private/any other
Industry	Agro/agri based/ancillary/cottage/handloom/textile/ tannery /any other
School	Primary/middle/high/higher secondary/college/ university/ professional college/any other
Mass Media	Personal television/public television/personal radio/public rad News papers/magazines/cinema/Road side theatre or any oth

14 Whether the school has required infrastructural facilities (such as space, black board,books,number of teachers etc)?

15 What is the mode of transportation you use for any medical emergency to take the patient to nearby hospital/doctor/town?

16 Do you need any other facilities which you don't have?

Yes no

If yes specify

17 Whether you are a beneficiary of Nutritional meals scheme?

Yes No

If yes, then state your reaction

18 Do you have drinking water facility?

Yes/No

19 Do you have drainage facility in your house?

Yes/ no

20 Do you have any water logging?

Yes/No

21 How much distance is the "Hospital/Maternity subcentre from your village?

22 How often they are opened?

23 Whether trained 'Dais' are available for service?

Yes/No

If yes, then state your reaction

18 Do you have drinking water facility?

Yes/No

19 Do you have drainage facility in your house?

Yes/ no

20 Do you have any water logging?

Yes/No

21 How much distance is the "Hospital/Maternity subcentre from your village?

22 How often they are opened?

23 Whether trained 'Dais' are available for service?

Yes/No

Health, Hygiene,and Sanitation

24 Did you have any epidemic diseases in the past two years in your village?

Yes/No

25 If no did you have any epidemic diseases in the past five years?

Yes/No

If yes, what disease?

How frequently you are sick?

26 When you get sick, what kind of treatment you prefer to have

Allopathic/Ayurvedic/Homeopathy/Quark/Unani/any other

Please state the reasons for preference

27 Was any child birth take place in your family in last two years?

Yes/No

28 Did any death take place in the last two years?

Yes/No

If yes what is the cause?

29 Do you believe that the children are the gift of god?

Yes/No

30 When any member gets sick do you restrict his/her diet?

Yes/No

If no why?

31 Whether the sick person is given boiled water when to drink during the sickness?

Yes/No

32 Whether you drink the drinking water as such, or treat it?

Yes/No

If no why?

33. Whether children and adults are all immunised?

    Yes/No

    If no, why?

34. Do you allow sick person to take enough rest?.

    Yes/No

    If no, why?

35. Do you teach your family members to take precautions against sickness?

    Yes/No

    If yes, what kind of precautions?

    If no, why?

36. Do you teach your family members on personal hygiene?

    Yes/No

37. Do you have a place for going to toilet?

    Yes/No

    If yes, what kind?

    Community/home/pay and use/open area

38. What are the physical location of toilets?

39. How do you clean your house?

    cow dung/water/any other

40. How do you keep your toilet clean?

41. Where do you dispose off your garbage?

42. Who collects the garbage and how often?

43. Where do you take bath?

44. Do you have rooms for taking bath?

    Yes/No

    If no where do the women take bath?

45 How frequently you take bath?

Twice a day/once a day/rarely

46 Do you wash cloths regularly?

Yes/No

47 Whether your family members wear chappals?

Yes/No

48 Do you fallow other habit of personal hygiene?

Hair cut/nail cutting/brushing the teeth

49 Do you wash your hands with soap after excreation?

Yes/No

Attitude

50 What is your opinion on health care?

51 What do you think of restricting the size of family?

52 What are the techniques used for family planning?

53 What are the enteitainments commonly you used to?

54 What is the specific benefits of education?

55 What is the religion's contribution?

Awareness

56 Do you listen Radio?

Yes/No

If yes, what programmes?

57 Do you watch Television?

Yes/No

If yes, what programme?

58 Do you read News paper?

Yes/No

If yes, what news items?

59 Do you have any rural organisations?

Yes/No

If yes, specify

Co-operatives/voluntary organisations/political organisations/film fans' association/

youth clubs/mahilamandals/any other

60 How many political parties are in your village?

61 How often political leaders visit your vilage?

62 Who is your M L A ?

63 Who is your M P ?

64 Who is your Panchayat President?

65 Who is the Chief Minister of Tamil Nadu?

66 Who is the Prime Minister of India?

67 Whether you go to any political party's meeting?

68 Did you vote in the elections?

State/Central/Panchayat

69 Did you participate in any campaign?

Yes/No

70 Did you participate in any demonstration?

Yes/No

71 If you are given a chance,what do you want to become?

72 Whom did you vote in the last election ?

73 To whom will you vote in coming election?

Customs

74 What is the age at marriage in the village?

75 What are all the festivals of your village?

76 Do you participate in all festivals of your village?

77 What norms are fallowed for marriage?

78 Do you have any contacts with any community?

Yes/No

If yes,whom?

State the contact

Marriage/sharing/living/occassionally

79 Do you believe in communal harmony?

Yes/No

80 Which castes and communities are there in your village?

81 What is the heirarchy?

82 Who are the influential people in your caste?

83 Who is the nattanmaikaran in your village?

84 Who is the dharmakartha in your village?

85 Who are the women leaders in your village?

86 Is there the practice of any segregation of women at certain time?

Yes/No

If yes, what is the nature and time of seggregation?

In cooking/worshipping/coming in front of elders

87 When any lady member of your family gets sick what do you do?

Go to hospital/ call doctor/ wait and watch/do nothing

88 When you have money what would you like to do?

In order of preference

1

2

3

89 Do you use face powder?

Yes/No

90 Do you wear shoes/chappals inside you home?

Yes/No

91 Is there the practice of female infenticide?

Respondents' details

Name of the respondent

Village

Caste

Taluk

Age (present app)

Education — Middle/Secondary/High/Higher secondary/ University/Professional/any other

Marital status — Married/Unmarried/Single

Occupation and Income

Period of Stay in the village

Family type — Multi unit/Mono unit/Extended type

Family Background

Sl No	Name of dependent	Sex	Age	Education	Marital-status	Occuption	Income

NOTE : This is a Sociological study and therefore an acedmic exercise Please feel free in giving answers and all answers will be kept confidential

1. What is the organisational setup (from State, District, Block and Village) ?

2 What are the specific duties ?

3 What is the distribution ?

4 Is this on paper ?

5 What are the research activities you undertake ?

6 What are the newer policies you undertake ?

7 What are the new type of medicines you use ?

8 What are the new methods of administration of medicines and surgery ?

9 What is the ratio of population and official ?

10 Whether blood bank is there in your hospital ?

11 What is the accesibility of transportation and blood acquisition etc ?

12 Is there any mobile clinic comes under your hospital ?

13 Is there any mobile eye clinic ?

14 Do you have any ambulance in your hospital ?

15 What is the mode of its lending ?

16 What are the charges ?

17 Whether doctors paid Non Parcticing Allowance ?

18 Do doctors practice outside hospital ?

19 Is there any training centre for the nurses ?

20 What are the numbers of nurses in the Village level, block level and district level ?

21 What are the community health given in this area ?

22 What are the courses taught in your Institution (short term/ long term) ?

23 Is there any Q I P Programme for which the nurses are sent?

24 What is the frequency of visits to the lower level health Institutions ?

25. What is the report process ?

26 What are the registers maintained ?

27 How the monitoring is done ?

28 Who does it ?

29 What is the timing of the O.P ?

30 Who does immunisation, childbirth, family planning, health inspection, sanitary inspection and water ?

31 Do you believe in God's help for cure ? Yes/No

32. Do you think that family members help in cure of patients ? Yes/No

33 If yes, then to what extent of help given ?

34 What are the attitudes of the patient help in quicker healing ?

35 Do you think that certain religion has some elements which cure patients quickly ? Yes/No

36. If yes, then explain ?

37 Do you think patients' exemptions from their normal duties help them in recovery ?

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Appendix B

A Index of repondent's income

Categories	Scores obtained (points assigned)	Frequencies
Low	Between 1 to 4 (i e Rs 0 to 600 per month)	167
Medium	Between 5 to 8 (i e Rs 600 to 2000 per month)	38
High	Between 9 to 10 (i e Rs 2000 to 3000 per month)	2

N = 207

B Index of ıepondent's educatıon

Categorıes	Scores obtaıned (poınts assıgned)	Frequencıes
Low	Between 1 to 2 (ı e upto class 5th)	151
Medıum	Between 3 to 4 (ı e upto Metrıc)	53
Hıgh	Between 5 to 6 (ı e upto Postgraduate level)	3
		N = 207

C Index of respondnets' occupations

Categories	Occupation	Points assigned
	Farming	7
High	Business	6
	Govt Service	5
Medium	Industrial Labour	4
	Services	3
Low	Agricultural Labour	2
	Others	1

D Status ranking of caste Hindu groups

Rank	Points assigned	Caste
1	11	Mannadiyar
2	10	Gaudar
3	9	Chettiyai
4	8	Naidu
5	7	Thevai
6	6	Naiker
7	5	Achariyar
8	4	Pandaiam
9	3	Vannai
10	2	Chakkiliyar
11	1	Pulaiyai Tribe

E Levels of Religiosity

Categories	Scores obtained	Frequencies
Low	2	26
Medium	3 - 5	55
High	6 - 8	126
		N = 207

F Levels of health

Categories	Scores obtained	Frequencies
Less	0 and 1	39
Moderate	2 and 3	96
Highly	4 and 5	72
		N = 207

சமூக சுகாதாரம் - ஓர் ஊர ஆய்வு

குறிப்பு: இது ஒரு சமூகவியல ஆய்வு. கலவித தொடாபுடைய ஆய்வாதலால், சேகரிச்சப்பட்ட செய்திகள் ரகசியமாக வைக்கப்படும். ஆகையால், கயவுசூர்ந்து வெளிபபடையாக சேளவிகளுக்கு பதலிக்குமாறு கேடடுக் கொள்ளப்படுகிறீகள்.

மத தொடாபுகள்:

1) இகிராமத்தில் மொத்தமுள்ள பல்வேறு மதங்கள் யாவை?

இந்து மதம்/ இஸ்லாம் / கிரிஸதுவம / மற்றவை

2) வழிபாடடுத் தலங்களுக்கு எத்தனை முறை செல்வீர்கள்?

தினமும / வாரம ஒரு முறை / வாரம் ஒரு முறை/ ஒருவாரகத்திற்கு ஒரு முறை/ மாதம் ஒரு முறை / எப்போதாவது.

3) எப்போதெல்லாம மற்ற மதததாரை சநதிப்பீர்கள?

எப்போதும் / எப்போதாவது / எப்போதும் இல்லை.

4) உங்கள் வீட்டில் கொண்டாடப்படும விழாகள் என்னென்ன?

5) உங்கள் குல தெய்வங்கள் யாவை?

6) உங்கள தெய்வஙகருக்கு காணிகை செலுதுவீாகளா? .. ஆம்/இல்லை

ஆம எனில் என்ன முறையில?

எப்போதெல்லாம்/ எத்தனைமுறை?

அதை என்னவெனறு அழைபபீர்கள?

7) உங்கள் காணிக்கை உஙகள் பிரச்சினையை தீாத்ததா? .. ஆம்/இல்லை

ஆம் எனில எந்த வகையில் ?

இலலை எனில் என்ன செயவீாகள்?

8) மத சடங்குகள் பொதுவான நிவாரணம தரும என்று நம்புகிறீர்களா?

.. ஆம்/இல்லை

9) வீடடில் விரதம் இருப்பதுண்டா? .. ஆம/இல்லை

ஆம எனில எத்தனை முறை/எப்பொழுது?

உணவு மறறும ஊட்டச் சதது:

10) உஙகள் உணவில் ஏதும கடடுப்பாடு உளளதா? ஆம்/இலலை

ஆம எனில எந்தவகையான கட்டுப்பாடு?

11) உங்கள் தின உணவில் என்னென்ன வகை ஊணவுகளை சோப்பீாகள்?

அரிசி/ காய்கறிகள / புருப்பு / பால மறறும பால் பொருடகள்/ முடடை/ இறைச்சி/ மாடடிறைச்சி / கோழி றைச்சி / பன்றி றைச்சி பசசை காய்கறிகள்/ கீரை வகைகள் / மறறவை.

12) நீங்கள் முளைதத பயிறு உண்பீாகளா? .. ஆம்/இலலை

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13) சுகாதார வசதி – மருத்துவனை/மருத்துவ நிலையம்/மருத்துவர் இல்லம்/ முதன்மை சுகாதார நிலையம்/ தாய சேய நல விடுதி/ பயிற்சி பெற்ற செவிலியர்/ ஆயா/ மற்றவை.

14) மின்சார வசதி – வீடு/விவசாயம்/தெரு விளக்கு/பாசனக்கிணறு.

15) போக்குவரத்து வசதி – பேருந்து/இரயில்/மாட்டு வண்டி/ மிதி வண்டி// மற்றவை

16) சந்தை – பொதுச் சந்தை/ தனியார் சந்தை/ இடைக் கரசாகள கூட்டுறவு சநகை / வார சந்தை/ மற்றவை.

17) தொலைத் தொடர்பு வசதி – அஞ்சலகம / தந்தி / தொலைபேசி / மற்றவை

18) வங்கி – பொதுத்துறை/ தேசியமயமாக்கப்பட்டவை/ தனியார்/ கூட்டுறவு வங்கி/ வட்டிக்கடை

19) நூலகம – பொது நூலகம்/தனியார் / நிரந்தர/தற்காலிக நூலகம் முழு நேர/பகுதி நேர நூலகம் / சுழல நூலகம்/ நடமாடும் நூலகம் / மற்றவை.

20) சாலைடை மருத்துவ வசதி – காலரா மருத்துவரை/ காலநடை மருந்தகம்/ சினை நிலையம்/ செயற்கை முறை கருவூட்டல நிலையம்/மற்றவை.

21) தொழில வசதி – விவசாயத்திற்கான தொழிற்சாலை/ விவசாயம சாராத தொழிலகள் / தொழிற்சாலை சாராதவை/ குடிசைத் தொழிலகள்/ கைத்தறி/ விசைத்தறி /தோல பதனிடுதல் மற்றவை.

22) கலவி வசதி – தொடக்கப் பளளி / நடுநிலைப பளளி/ உயர்நிலைப பள்ளி மேல நிலைப பளளி.

23) செயதி தொடர்பு– கருப்பு வெள்ளை தொலைக் காட்சி/ பொதுத் தொலைக் காட்சி கருப்பு வெள்ளை வானொலி/ பொது வானொலி/ செய்திக் கான செய்தி ஏடுகள / திரைப் படம்/ திரையரங்குகள்/ மற்றவை.

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24) இந்த ஊர் பள்ளிகளில தேவையான வசதிகள் உள்ளனவா? (இடம்/ கருமப்பலகை/ நூல்கள்/ ஆசிரியர்களின் எண்ணிக்கை) .. ஆம்/இல்லை.

25) அவசர சிகிச்சைக்கான நோயாளியை எவ்வகையில (போக்குவரத்து) அருகாமையில உளள மருத்துவமனைக்கு/ மருத்துவர்/ நர்சுக்கு எடுத்துச் செலவுகள.

26) தற்போது இல்லாத வேறு வசதி உங்களுக்கு தேவையா? .. ஆம்/இல்லை

ஆம் எனில் எவ்வகை?

27) உங்கள் வீட்டில யாராவது அரசு வழங்கும் சலுகை உண்ணுகிறார்களா?

ஆம எனில் பயன என்ன?

28) உங்களுக்கு குடிநீர் வசதி உளளதா? .ஆம்/இல்லை.

29) உங்கள வட்டில் கழிவுநீர் வடிசால் வசதி உள்ளதா? .. ஆம்/ இலலை

30) உங்கள வீட்டில எங்கேமை தண்ணீர் தேங்கி நிற்கிறதா? .. ஆம/ இலலை

31) உங்கள கிராமத்திலிருந்து எவ்வளவு தூரத்தில் மருதுவமனை/ தாய் சேய் நல விடுதி உள்ளது?

எப்போதெலலாம் அவை திறந்திருகுமு?

32) பயிற்சி பெற்ற பிரசவம பாாகுமு பெண்கள இருகிறார்களா? .. ஆம/இலலை

பொது சுகாதாரமும் தூய்மை மற்றும சுறறுப்புற சுகாதாரம.

33) கடந்த இரணடு/ஐநது வருடங்களில் ஏதாவது தொற்று நோயால பாதிக்கப்பட்டாகளா? .. ஆம/ இல்லை

ஆம எனில், என்ன நோய்?
நோயுற்ற காலம?
எத்தனை முறை?
என்ன காரணம?

34) உங்களுகு உடல் நலமிலலாத போது எவ்வகையான மருத்துவம எடுத்துக் கொளவீர்கள?

அலோபதி/ஆயுர் வேதம/ஓமியோபதி/யூனானி/நாட்டு மருந்து/மந்திரம/மற்றவை.

ஏன் இமமுறைமை பயன்படுதுகிறீர்கள?

35) கடநத இருவருடங்களில் உங்கள் குடுமபத்தில் குழநதை பிறந்துளளதா? .. ஆம/இல்லை.

36) கடநத இருவருடங்களில் யாரேனும் இறந்துள்ளனரா? .. ஆம/இலலை.
ஆம எனில இறப்பிற்கான காரணம?

37) "குழநதைகள கடவுளின் அனபளிபபு" என்பதை நமபுகிறீர்களா?

38) குடுமபதகினா உடல் நலம குன்றினால உணவு வழங்குவதை கட்டுப படுதுவீர்களா? .. ஆம/இல்லை

இல்லையெனில, ஏன?

39) உங்கள் வீட்டில குடிநீரை சுத்தப்படுதத அருநதுகிறீர்களா? .. ஆம்/இலலை

இல்லை எனில, என்?

40) உடலநலம் குன்றியவருக்கு குடிபபதறகு காயச்சிய குடிநீர் அளிப்பீர்களா?

..ஆம/இல்லை.

41) உங்கள் வீட்டில் குழந்தைகள மற்றும பெரியோர்கள யாவருக்கும் தடுப்பூசி போடப்பட்டுளளதா? .. ஆம்/இலலை.

இல்லையெனில் ஏன்?

42) உடல நலம் குறைவானவருகுகு ஓய்வளிபபீர்களா? .. ஆம்/ இலலை.

43) நோய் வராதிருகக உங்கள் குடுமபத்திறுகு முன்னெச்சரிக்கை நடவடிக்கைகள குறிதது கறபிபபதுண்டா? .. ஆம/இல்லை.

ஆம எனில எவ்வகையான நடவடிக்கைகள்?

இலலை எனில ஏன்?

44) உங்கள் குடுமபதினருக்கு தன் சுகாதாரம பறறி கற்பிப்பதுண்டா?

.. ஆம/இலலை.

45) உஙகள் வீட்டில் கழிவறை உளளதா? .. ஆம்/இல்லை.

இருப்பின எவ்வகை .. பொது/ வீட்டல/ சாசு கொடுதது பயன்படுதது வகை திறநதவெளி.

46) உங்கள் வீட்டில/ஊரில் எந்த இடத்தில் கழிவறை உள்ளது?

---- எவ்வாறு சுத்தப்படுத்துவீர்கள்?

மாட்டு சாணம்/ தண்ணீர்/ மற்றவை.

48) உங்கள் கழிவறையை எவ்வாறு சுத்தமாக வைத்துக கொள்வீர்கள்?

49) உங்கள் குப்பையை எங்கு அப்புறப்படுத்துவீர்கள்?

50) யார் குப்பையை சேகரிக்கிறார்கள்?

51) நீங்கள் எங்கு குளிப்பீர்கள்?

52) உங்கள் வீட்டில் குளியலறை உள்ளதா? .. ஆம/இலலை.

53) இல்லையெனில பெண்கள் எவ்விடத்தில் குளிப்பார்கள்?

54) எப்போதெல்லாம் நீங்கள் குளிப்பீர்கள்?

தினம் இருமுறை/ தினம் ஒரு முறை/ எபபோதாவது.

55) உங்கள் துணிகளை தினமும் துவைபபதுண்டா? ..ஆம்/இலலை.

56) உங்கள குடுமபதினர் அனைவரும் செருப்பு அணிவதுண்டா? ஆம/ இலலை.

57) தன் சுகாதாரத்திறகாக மறற பழக்கங்களை பின்பற்றுகிறீர்களா?

முடி திருத்துதல்/நகம வெட்டுதல்/பல் தேய்த்தல்/ மற்றவை.

58) காலைக் கடனகளை முடித்த பிறகு சோபபு கொண்டு கைகளை கழுவுவதுண்டா?

..ஆம்/இல்லை.

59) விவசாயம்:

வரிசை எண்.	நிலம் அளவு	முக்கிய பயிர்	விளைச்சல்	முறை	சாகுபடி	பாசனம்	உழவு முறை	தொழில் நுட்பம்	சேமிப்பு வசதி.

மனப்பாங்கு:

60) சுகாதாரத்தைப பற்றி என்ன கருதுகிறீர்கள்?

61) குடுமப அளவை கடடுப்படுத்துவது பற்றி என்ன நினைகிறீர்கள்?

62) குடுமப கட்டுபபாடடில பயன்படுதப்படும் முறைகள யாவை?

63) உங்கள் பொழுது போக்கிற்கான முறைகள் யாவை?

64) கல்வியின் குறிப்பான நன்மைகள் யாவை?

65) மதத்தின் உதவிகள் யாவை?

விழிப்புணர்ச்சி:

66) வானொலி கேடபீர்களா? .. ஆம்/இலலை.
ஆம் எனில் என்ன நிகழ்சிகள்.

67) தொலைக்காட்சி காண்பீர்களா? .. ஆம்/இல்லை.
ஆம் எனில் என்ன நிகழ்ச்சிகள்.

68) செய்தித் தாள் வாசிப்பதுண்டா? .. ஆம்/இல்லை.

69) ஆம் எனில், என்ன செய்திகள்?

69) உங்கள் ஊரில் ஏதேனும் கிராம அமைபபுகள் உள்ளனவா? ஆம்/இல்லை.
ஆம் எனில், குறிப்பிடவும்.
கூடடுறவு/தொண்டு நிறுவனம்/அரசியல கட்சி/நடிகாகள் ரசிகர் மன்றம்/
இளைஞா மன்றம்/மகளிர் மன்றம்/மற்றவை.

70) உங்கள் ஊரில் எத்தனை கட்சிகள் உள்ளன?

71) எப்போதெல்லாம் கட்சி பிரமுகர்கள் உங்கள ஊருக்கு வருகிறார்கள்?

72) உங்கள் சட்டமன்ற உறுப்பினர் யார்?

73) உங்கள் பாரளுமன்ற உறுப்பினர் யார்?

74) உங்கள் ஊராட்சி மன்ற தலைவர் யார்?

75) தமிழ் நாட்டின் முதலமைச்சர் யார்?

76) இந்தியாவின் பிரதமர் யார?

77) ஏதாவது அரசியல கட்சி கூட்டத்திற்கு செல்வதுண்டா?

78) தேர்தலின போது வாகககளித்தீர்களா?
மாநிலம் /மத்திய /ஊராட்சி தேர்தல்

79) வாக்கு சேகரிபபதில் பங்கேற்றீர்களா? ..ஆம/இலலை.

80) நீங்கள்ள் போராட்டங்களில பங்கேற்றதுண்டா? ..ஆம்/இல்லை.

81) கடந்த தேர்தலில யாருககு நங்கள் வாக்களித்தீர்கள்.

82) வரும் தேர்தலில் யாருககு வாகககளிபபீர்கள்.

83) உங்களுககு வாய்ப்பு கிடைக்குமானால் யாரர்க விரும்புகிறீர்கள்?

பழக்க_வழக்கங்கள்:

வ
84) உங்கள் கிராமத்தில் திருமண வயது எவ்வளவு? ஆண / பெண்.

85) உங்கள் திருமணத்தில் பின்பற்றப்படும் விதிமுறைகள் யாவை?

86) உங்கள் கிராமத்தின் திருவிழாக்கள் யாவை?

87) நீங்கள் எலலா திருவிழாகளிலும பங்கேற்பதுண்டா?

88) மற்ற சமூகததாருடன் தொடர்பு கொண்டுள்ளீர்களா? ஆம்/இலலை.
ஆம் எனில் எவ்வகையில்?
திருமணம்/ பரிமாற்றம்/ வாழ்தல்/ எப்போதாவது சந்தித்தல்.

89) சமூக நல்லிணக்கத்தில் நம்பிக்கை உண்டா? ஆம்/இல்லை.

90) உங்கள் ஊரிலுள்ள மதங்கள்/சாதிகள் என்னென்ன?
எவையெவை பெரும்பாண்மை/முதலிடம் வகிக்கின்றன.

91) உங்கள் சாதியின் முக்கிய பிரமுகர் யார்?
ஆண் ..... பெண்.....

92) உங்கள் கிராமத்தின் நாட்டாண்மைக்காரர் யார?

93) உங்கள் கிராமத்திலுள்ள கோயில் தர்மகர்த்தா யார்?

94) உங்கள் கிராமத்தில் பெண் தலைவர்கள் யாவா?

95) பெண்களை குறிப்பிட்ட காலங்களில் விலககி வைககும் பழக்கம் உள்ளதா?
ஆம்/இல்லை.
ஆம் எனில், எவ்வகையில், எப்போது?
சமைப்பதில/வழி பாட்டில்/பெரியவர்கள் எதிரில் வருவதில்.

96) உங்கள் குடும்ப பெண்மணிக்கு உடல் நலக குறைவுக இருக்குமபோது என்ன செய்வீர்கள்?

மருத்துவ முனைக்கு எடுகத செல்லுதல்/ மருத்துவரை அழைத்தல்/

97) உங்களிடத்தில் பணம் ஒருகும் போது என்ன செய்வீர்கள்?
வரிசைப்படி கூறவும்.

1.
2.
3.

98) முகப்பூசசு பயன்படுத்துவதுண்டா? ஆம்/இலலை.

99) வீட்டின் உளளே செருப்பு அணிவதுண்டா? ஆம/இல்லை.

100) கோலம் போடும வழக்கம் உணடா?

101) பெண் குழந்தையை கொலலும் பழக்கம் உள்ளதா?

பெயர் : ஊர்:
தாலுக்கா:

சாதி :
மதம் .
வயது (சராசரியாக)
கல்வி:

திருமணம் ஆனவர் / ஆகாதவா / தனித்தவர்.

தொழில் மற்றும் வருவாய்:
கிராமத்தில் தங்கியுள்ள காலம்:
குடுமபம்: கூட்டுக குடும்பம்/தனிக் குடும்பம்/ விரிவான வகை.

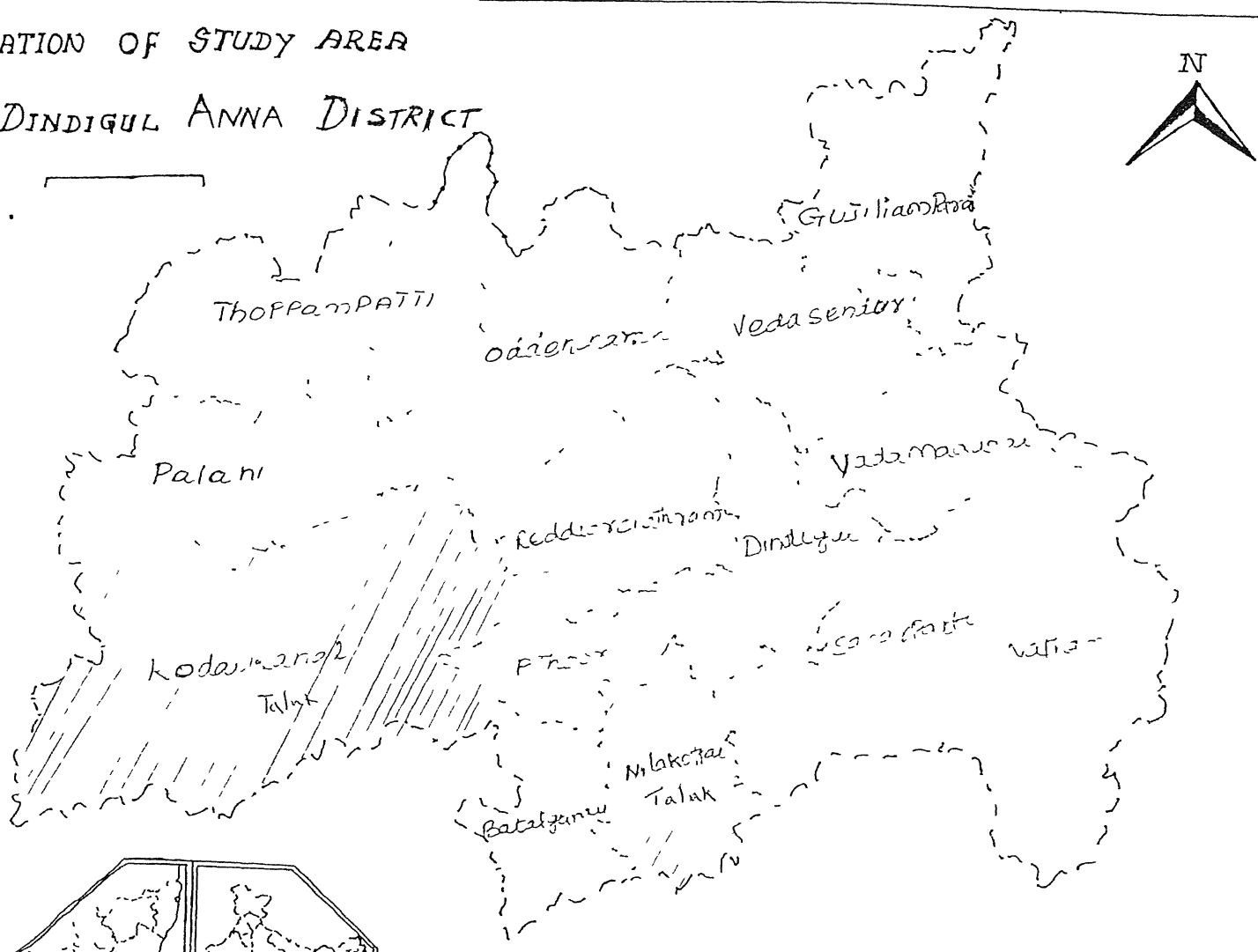
குடுமப பின்னணி:

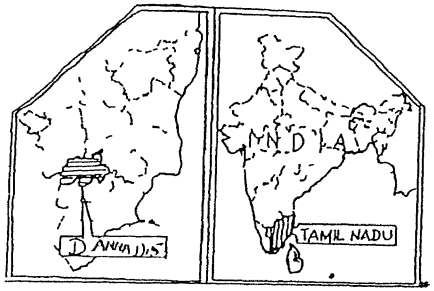
வரிசை எண.	சார்நதோர்.	பால்	வயது	திருமணம் ஆனவா	தொழில	வருவாய

ஆயவாளரின பெயர்: திரு க. சீனிவாசன்,
புலமை மறறும் சமூக அறிவியல துறை,
இநதிய தொழில நுடப கழகம்,
கான்பூர். உத்திரபிரதேசம்.

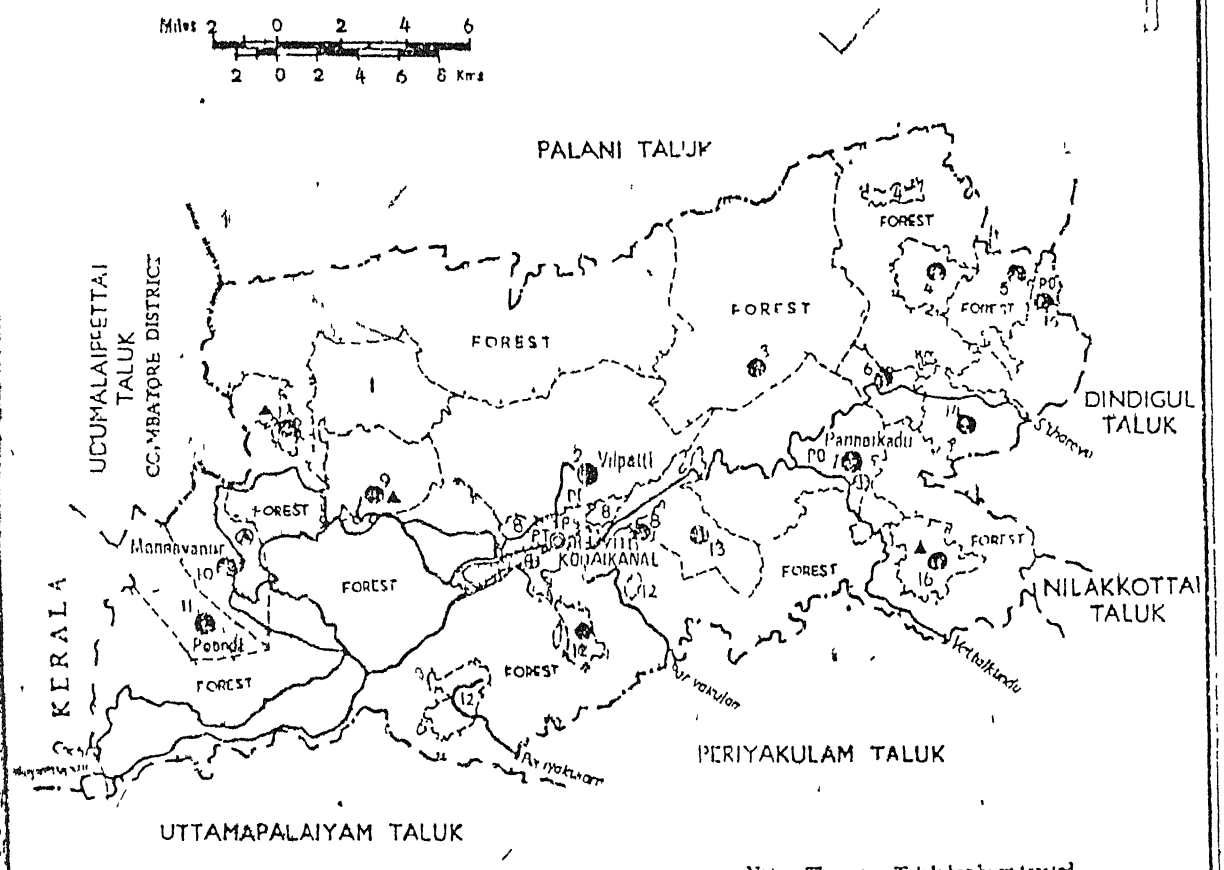
LOCATION OF STUDY AREA

DINDIGUL ANNA DISTRICT





KODAIKANAL TALUK



Note - The entire Taluk has been treated as a single Panchayat union

Boundary, State
" District
" Taluk
" Village with Location Code Number 12
" Forest
Taluk headquarters
Village having Population 500 - 999
" " 1000 - 4999
" " 5000 & above

Important Road
Post Office Post and Telegraph office PO PT
Police station PS
Hospital, Primary health centre, Maternity and Child welfare centre
Rest house, Travellers bungalow RH
Urban area with Location Code Number VIII

Date Slip

This book is to be returned on the date last stamped